To the Editor:

I've just read Louanne Kennedy's excellent article on voluntary and proprietary hospitals in the November/December Health PAC Bulletin. The irony of the situation you cover is that the voluntary hospitals could probably save themselves if they developed an alliance with labor and the poor and put together a decent regulatory system based on prospective reimbursement and utilization control. Such a system could easily be shaped to channel money away from the proprietaries and into the voluntaries and if it put Medicaid patients in the mainstream and provided for decent wages for hospital workers it might be politically irresistible, even now.

Apparently, however, the voluntaries are not going to take on the proprietaries, are going to persist in regarding labor and the poor as their enemies and are going to resist regulation to the end, as if, despite all the evidence to the contrary, they still believe that public and private money will flow their way in unlimited quantities, as long as the hospitals demand it. It's all so irrational.

I will be sorry to see voluntary hospitals close. At their best they are concerned about the level of care their patients receive. They do provide some free care, which is more than can be said for the proprietaries. And in California at least they provide far more and far better care to Medi-Cal recipients than do the proprietaries.

But they will be closing. It's not so surprising, though. If the railroads, the auto industry and the steel industry can all destroy themselves why shouldn't the voluntary hospitals do this, too. It does amaze me though that people can still believe in an economic theory that presupposes companies will act in their own best interests.

Sincerely,

Stanton J. Price
Santa Monica, CA

To the Editor:

On February 24th, Cong. Jim Weaver of Oregon introduced "The Organic Farming Act of 1982," a bill which calls for research and information on organic farming systems at six regional centers around the country. Along with providing relief for farmers from cost pressures of petrochemically based fertilizers and pesticides, the bill would have pay-offs for environmentally concerned citizens and health-conscious consumers as well.

Cong. Weaver plans an early May hearing on the bill and, if response to the bill is strong, hopes to get committee action on it by early summer.

Interested supporters can help move the bill forward by writing their Representatives in Congress, asking him/her to co-sponsor the bill.

Sara Ebenreck, Director
Washington Office
Rodale Press
Notes and Comment

Hearing the words “philosophy” and “health” in the same sentence from a new entrant into New York City’s Health and Hospital Corporation revolving door management was a refreshing surprise. Mayor Koch has never been known to place health high on his priority list, let alone have a “philosophy” about it, and most of his appointees have been happy to discuss the city’s health policy mostly in terms of savings—dollars rescued for “more important” services, i.e. Fire and Police.

The sentence came from the mouth of Dr. David Sencer, the new Commissioner of Health, at the March forum of the Public Health Association of New York City. Many had awaited his arrival as head of the Department of Health. His reputation as a knowledgeable public health professional seemed to promise that he could revive his agency to its reasonably functional state of a decade ago.

After opening his talk with a self-effacing “I just got here” disclaimer and the mandatory joke—Sencer bears an uncanny resemblance to Bob Newhart in both looks and delivery—he set his audience straight.

Public health began somewhere in the murky past, before 1959, he explained. In those halcyon days, urban public health departments had a properly modest view of their role: keep restaurants clean, give kids shots, and prevent the spread of VD.

Then came the activism of the 60’s. Everything began to get out of hand. People started confusing preventive medicine with curative medicine. Public health departments expanded to care for sick people, organizing and delivering ambulatory care—about which, Dr. Sencer implied, they knew nothing. Worse still, they were (and are) ill equipped to compete with larger, more powerful providers for funds and other resources necessary to deliver such services.

The obvious conclusion, said Sencer, is to return as rapidly as possible to the good old days of narrow focus on preventive medicine and policing public sanitation. The latter, he suggested, might be expanded somewhat in exceptional circumstances to include monitoring and regulating acute health care providers via the health department’s “bureaucracy.” "I'm a great believer in bureaucracy,” he explained, "I believe public bureaucracy is the skeleton, to which must be joined the muscle of the community and of the private sector.”

Elaborating on this metaphor, he made it clear that the community muscle is found primarily in the city’s major medical providers, i.e. teaching hospitals and medical schools. But without a skeleton it “merely quivers.”

Sencer’s dissection of the role of public health would be amusing if it were not for two somber realities. One is that far too many otherwise well-informed health professionals share the historical ignorance upon which it rests. The other is that the current realities of health and health care in New York and other cities are such that the Sencerian vision all too easily complements the fashionable Reaganesque shuffle of “letting the private sector do it.”

Public health history did not begin in the 1950’s. For more than a century debates have raged in this country, in Western Europe, and virtually everywhere else over which curative and preventive services should be the direct responsibility of the government. The variation in the scope and content of the services offered has been enormous in the United States, over time and from locality to locality.

The debate has been particularly intense in the urban Northeast and, Dr. Sencer might be surprised to learn, in New York City most of all. As George Rosen pointed out in an essay in From Medical Police to Social Medicine written shortly before his death last year, New York City maintained an extensive network of dispensaries in the 1920’s which were forced out of existence by the county medical societies. Indeed, as the Health/PAC report on the late 1970’s demise of the Department shows, much of its history can be seen as a struggle between the (generally expansionist) views of those favoring “district services” and the (generally reductionist) perspective of those advocating more centralized, categorical administration.

Sencer’s sharp distinction between “preventive” and “curative” medicine can also be questioned—one prominent community health physician in the audience did just that. If the last 20 years of experimentation and innovation in ambulatory care have taught us nothing else, they have shown that attempting to separate routine services in these two areas seriously weakens the impact of both. This is the basis of the very concept of “primary care.”
Sencerian revisionism is not an academic matter. One would have to be deaf and blind not to be aware that health services accessible to the poor—particularly the uninsured poor or "medically indigent"—are extremely meager and under attack from all quarters in this country. New York City, which contains the largest medically indigent population, simply cannot afford the Reaganomian pretense that minimal Medicaid and Medicare combined with the wisdom and charity of the private sector will weave safety nets for all.

New York health activists have recently cited at least two examples of how dangerous this approach can be:

1. The Department of Health currently runs over 50 child health stations, including 27 Pediatric Treatment Centers which also deliver curative medicine. A proposal periodically surfaces to turn all 50 over to the Health and Hospitals Corporation.

   Would Dr. Sencer park his Mercedes in a used car lot for safekeeping? The HHC closed many of its own well-baby clinics in the late 1970's because they were costly and didn't generate sufficient Medicaid revenues or inpatient admissions.

2. The Department currently provides school health services. Suggestions have been raised to transfer this responsibility to the Board of Education or elsewhere.

   Would the new provider offer the same care? There's no guarantee. Of course, there is no guarantee that the health department will be providing even its current meager services either. The $1.5 million budget increase requested for School Health Services for next year is pathetically inadequate, as everyone in the Department is aware. Whoever is saving money at the expense of children's health ought to have a good reason.

   In both these cases, the Department of Health originally took responsibility for providing these services because no one else demonstrated the capacity or commitment. If anything, recent and future cutbacks reinforce the need for this role of provider of last resort.

   New York City's Department of Health once was considered the finest in the country. It pioneered numerous forms of personal health services long before Dr. Sencer was born, including school health exams (1905); public health nursing (1902); well-baby clinics with milk (1908); and dental clinics in schools (1921). All of these services were available free of charge to the city's poor.

   If the current Department of Health reminds Dr. Sencer of a skeleton, it may be because it is being reduced to one by successive waves of administrators. And the muscle-bound state of the city's major hospitals owes much to public officials prepared to cheer them on and write them checks.

   The next time the new commissioner studies anatomy, he might take the time to notice that a healthy organism needs more than muscle and bone. It needs a head in touch with its environment and able to cope with it.

— The New York Work Group

(The NYWG was established by Health/PAC to monitor government programs in New York. We hope to establish similar groups in other cities and states, and would appreciate hearing from any volunteers.)
Vital Signs

Senators Alan Cranston and S.I. Hayakawa on behalf of their local wine industry.

Senator Cranston, like many other members of the California congressional delegation, received hefty contributions from the Wine Institute for his 1980 campaign. American politics appear to be on a downward trend: before decisions were made in back rooms; now they're made in cellars.

Jon Steinberg

Compromising

Positions

As the United States moves into the era of limits with the hesitancy of a drunk entering a dark room, hospitals are among those tripping on the depression glass. The small ones are falling away. The largest are growing larger, more sophisticated in their medical and reimbursement technology, and even more powerful politically.

Often state governments are caught in the middle, attempting to appease communities uneasily aware that their hospitals are turning into skeletons or rubble while catering to the needs of the major teaching hospitals.

Because it contains the most medical empires and large numbers of small hospitals—though not nearly so many as a decade ago—New York represents the most advanced form of this conflict. In 1978 the state legislature set up the Council on Health Care Financing in response to cries for help from hospitals hard hit by the state’s rigid cost containment program (see “A New Way to Stake Claims,” July-August, 1981, Bulletin).

After six months of behind the scenes wrangling with the State Health Department and the Hospital Association of New York State (dominated largely by small hospitals) over reimbursement policies, the Council has come up with a compromise proposal. The problem is, very few people appear happy with it.

The Council wants to give the State Health Department authority over all third party payers. To make this more attractive to hospitals, the proposal offers a bad debt and charity pool funded by a three percent surcharge on all third party payers.

The state is offering the equivalent of a kiddie wading pool for a herd of thirsty elephants.

Despite this sweetener, the Council plan has attracted little support among hospital administrators. Public hospitals, particularly New York City’s Health and Hospitals Corporation, think the state is offering the equivalent of a kiddie wading pool for a herd of thirsty elephants. The state pool is small to begin with, and public hospitals would be allotted less than a quarter of it even though they serve a disproportionate number of indigent patients. An earlier version of the proposal doled out the money according to need, but this was withdrawn to assuage upstate and suburban opposition. The needs of the poor and the needs of state legislators don’t always coincide.

Even so, the rest of the hospital industry has not been
won over. At a recent meeting, Hospital Association members voted overwhelmingly to reject the Council proposal. They were particularly put off by their profound distrust of the State Health Department. During the past six years the Department's Medicaid cost containment program has provided the final shove for many hospitals teetering on the edge of bankruptcy, and the surviving institutions see no reason to applaud a plan which gives it control over Medicare as well.

State Health Department officials profess to be insulted and hurt by this suspicion of their good intentions, but they will have a tough time pushing their plan through. On April 1 it was sent off to Washington for an okay. The next step is approval by the state legislature, where it will encounter heavy opposition with or without hospital industry support.

New York Work Group

National Security

The Children's Defense Fund has published "A Children's Defense Budget: An Analysis of the President's Budget and Children," which makes some telling comments on the Reagan Administration priorities.

Here are a few excerpts:

President Reagan proposed an additional $3 million cut in the childhood immunization program for fiscal year 1982 which would eliminate immunizations for 75,000 children at risk. In fiscal year 1983 he plans to cut $2 million more. The Defense Department spends $1.4 million on shots and other veterinary services for the pets of military personnel. Additional millions are spent on the transportation of military pets when personnel are transferred. If the veterinary benefits for military pets were eliminated, 35,000 low income children could be immunized instead....

The State of Virginia has fewer than 160 full time home-making aides serving more than 2,500 aged, blind, disabled persons and families with handicapped children at home. The Pentagon has 300 personal servants tending to fewer than 300 senior officers, none of whom reports himself seriously disabled. Virginia's program costs about $1 million a year. The Pentagon's program costs over $5 million a year. President Reagan cut Virginia's program by more than a third; he increased the Pentagon's program by 15 percent....

Secretary of Defense Weinberger has a private dining room at the Pentagon at which only about 100 persons are eligible to dine. It has a staff of 19 and each meal served costs the diner an average of $2.87 and the taxpayers an additional $12.06. President Reagan forced the low-income children of working mothers in child care centers to give up their mid-morning supplement of juice and crackers. Each time Secretary Weinberger or one of his select associates has lunch, 40 of those low-income children must go without orange juice or milk. More than one million mid-morning supplements for low-income children now to be lost each year could be restored if Secretary Weinberger and his colleagues ate in other Pentagon dining rooms, or contracted with a private food company to run his private dining room on a self-sustaining basis.

The report goes on to point out that by eliminating preventive care programs, the government will increase government costs over the long term while hurting millions of children.

David Kotelchuck

David Kotelchuck is on the Health/PAC Board.

Time Warp

Under the heading "Red Tape Flap," the Wall Street Journal recently reported that the White House has asked OSHA to drop employers' worker illness-injury logs to cut paper work. This certainly sounds like a worthy effort, since it is easy to imagine managers spending hours toiling at their desks recording every little scratch, allergy, and lost limb.

The Reagan Administration will be relieved, however, to learn that the burden is not as great as it imagined. A new study by the Bureau of Labor Statistics found that although previous estimates had calculated that it took four minutes to fill out the OSHA 200 form and 20 minutes for the OSHA 101 form, a BLS survey in three states found that the actual times are now 2.1 minutes and 5.9 minutes, respectively.

Reagan OSHA administrators, who are firm believers in self-reporting by employers, might note that the earlier figures were obtained by asking management. This time, at least two BLS representatives stood by with stopwatches.

The BLS also asked the participants if they "perceived recordkeeping as a burden," and found that the answer was generally "no": the employers said they would have to record injuries and illnesses anyway for insurance and other purposes.

Jon Steinberg
I had arranged to meet Tony Mazzocchi at the office of the health and safety director of a New York-based union. He had come in from his new home in New Jersey.

Until recently, he was the health and safety director of the Oil, Chemical, and Atomic Workers union (OCAW), based in Denver. Last August he narrowly lost the election for the union presidency and was stripped of his position. His only OCAW post is international representative—without salary. However his reputation as one of the most insightful analysts of the occupational health and safety movement is not in danger.

Dressed in a brown turtleneck, talking in his customary informal manner, Mazzocchi posed a sharp contrast to the two coat-and-tie formal union officials he was conversing with.

"I'm sort of in limbo now," he told me, "What I'll be doing will become clearer in the next few weeks." About himself he would say no more.

He was quite voluble, however, on his favorite topic. "The health and safety movement is again under siege," he began. "The Administration has cleverly, in my opinion, dismantled the operation in a not totally visible way. The Occupational Safety and Health Administration played a great role in dramatizing the issues. It provided a platform, a stage, for this drama to get played out on, in view of the total population.

"As a result, many diverse actions occurred. Community groups such as Committees on Occupational Safety and Health were formed. A lot of unions developed rather sophisticated health and safety departments."

His eyes, wide with enthusiasm as always when he talked about the movement, abruptly narrowed. "With Thorne Auchter leading the show as OSHA director, or any other appointee the President decides upon, the current policy of dismantling will continue. For instance, standard setting. That was always an opportunity for us in the labor movement to petition for promulgation of a particular standard, to provide evidence on why we need it to best protect workers at the point of production. Well, Auchter is just going to bury any petition that comes in. In effect, that's already been said. "Of course," he added quickly, "on top of that you have an economic crisis in which fear is travelling through the workplaces. Even where some of these problems are highly visible workers are reluctant to take an aggressive stance to deal with them. The preservation of jobs is foremost on everybody's minds. Legitimately so and logically so. Environmental and economic blackmail is real. It's a very difficult time even to conduct a straight economic action. I just do not see people going into the street over this issue. We're in a time of concessions and very few unions are putting themselves in a position where they can extract what is necessary."

"We suspect that we live about seven years less than one would normally expect."

He smiled with an energetic wave of his hand. "But of course we're a decade further down the line and we know a lot more. As I say, many unions built departments and they are going to proceed under their own steam. I think many of the health and safety confrontations will be between a union and a specific industry without the government being involved. OSHA will maintain itself as an agency, make a few mild forays once in a while. That's been a tactic used by previous administrations to keep a facade of protection. But it's not going to inter-

Peter Medoff is a member of the Health/PAC staff.
vene in any substantive way."

He paused for a moment, weighing the likely prospects. "The effects of working throughout the 1950's, 1960's, and 1970's are going to be more apparent in the 1980's. Birth defects and childhood cancer, for example, are going to be more visible. The responses are hard to predict. It's an issue that is not going to go away. Things are going to get worse as a result of the economic crunch. Cutbacks, lack of maintenance, speedups, drives for increased productivity will all make health and safety problems that much more severe."

When asked about state and local intervention, he smiled ironically. "That's taking us back before OSHA; the state and local governments will be the graveyard of any hopes. A number of issues will be pushed in some states, but as the economic pressure grows it will be similar to other times I've lived through, even progressive times. You have an opportunity to do something progressive in one state, your laws get too tough and industry runs down South or someplace else, and that's going to overwhelm everybody."

In recent weeks, Mazzocchi had been working on another tack, and his energy and enthusiasm intensified as he launched into a discussion of the project. "I see more opportunity for alternative structures. For instance, where OSHA had a standard setting process that allowed us to get the story out in the open. I've been talking to a number of scientists, trade unionists and community types about creating a standard setting process that has a bias toward working people. The process would include scientists and workers who really want to provide the ultimate in standard protection for workers. After all, OSHA and most Federal agencies have incorporated by reference standards promulgated by consensus organizations dominated by management.

"So I think it's a time for a worker consensus to emerge. We'd provide a mechanism for receiving information about substances and come up with recommended standards. Then we'd fight to have them incorporated by reference just like industry has. Over 90 percent of the standards in the Occupational Safety and Health Act are industry promulgated."
“Another area,” he continued with an almost boyish delight, “is worker control over medical-industrial hygiene at the plant level. Even in this period of economic duress we ought to be setting up separate entities and have management contribute funding. A lot of it wouldn’t even be new money since management is already spending on industrial hygiene. It’s a fight over control, and I think it has to take place in this decade. And it can.

“Record keeping would be centralized and confidential. The employer would see only what the union sees—aggregate data. We’re capable of doing this overnight.”

Unlike many specialists in occupational health and safety, Mazzocchi has always seen the issue in the context of a broader analysis of the work process and society itself, and has been outspoken in expressing his views. “My concept is that catastrophic diseases are built into the industrial process,” he said, “Cancer, birth defects, heart disease, are so built into the mode of production that unless we address how we do things and what we produce, we’ve got serious problems. When we address them in a way that gives people some power down below, we’ll be on the way to dealing with ultimate remedies.

“I think a lot of people don’t understand the way the industrial process works and that has to come first. They think in terms of bad guys against good guys, not imperatives of production to maximize profit.”

He smiled ironically. “The bosses are right in that respect. They say you have to disease people, that they can’t afford better protection. Essentially, they’re saying that working people have to give bosses a subsidy, using up their lives. Cost-benefit is true.

“Birth defects and childhood cancer are going to be more visible.”

“For instance, in the oil industry we’ve had a demand that we want to know how long we live. The industry has never told us; they have all the data. We suspect, based on pension data, that we live about seven years less than one would normally expect. That’s a handsome subsidy. And then you take morbidity and the quality of life on top of that and you’re dealing with appreciable subsidies.

“Industry is one big welfare basket case,” he exploded with mock wonder, “If we took our subsidies back and said, ‘Let free enterprise work,’ we’d find it isn’t very free or very enterprising. They wouldn’t make it.

“That seven years is a big piece of somebody’s life. I can’t say it’s a loss of productive life because there is always somebody from the army of unemployed to take your place. In real dollar terms it doesn’t cost. But it’s a subsidy that industry extracts, and it’s worth a lot. You can work a person and expose him or her. If you had to develop an alternative, safer method, you could produce less, no question about it.

“Industry is one big welfare basket case... It isn’t very free or very enterprising.”

“I never bought the argument that healthier places are more productive. I think that comes from people who don’t understand the nature of the workplace. If you die young, you help them in a lot of ways. You enhance their pension plans and you probably subsidize the executive pension plans.”

Although a strong advocate of building coalitions beyond the trade unions, Mazzocchi was unenthusiastic when asked about community-based alliances.

“Broad coalitions around health and safety issues are always difficult,” he explained, “If a community is assaulted by a substance, people normally act to get rid of the plant, which of course creates divisions. I think the best opportunity for a broad coalition is working with the health community. The models established by the COSH’s have to be encouraged. There are alternatives like the standard setting organizations I mentioned. That kind of worker control, to me, takes first priority because there is a chance to move on it.

“If you try to establish local standards, it’s easy for an industrial entity to say, ‘Hey, you priced us out of the market and we’re going to move.’ That type of thing could happen in a middle class community that really doesn’t want industry around anyway, but I’m talking about industrial communities. Economic threats succeed. Where you have service cuts there are opportunities for coalitions. A subway can’t up and run away to Mississippi.

“And the whole question of our children can easily be developed into a coalition base.
Everybody is concerned about children. We shouldn’t abandon all the good slogans to the right. “The right to life” is a great slogan, but the real fight is over the rights of our kids to be born healthy and to survive. That’s an issue that emanates from the workplace and can incorporate broad sections of the population. Most workers feel that they’re working at lousy jobs because they want to make it better for their kids. If they doom their kids by working at these jobs, they’re going to be angry about it. And as I’ve said, the 1980’s will be a time for genetic confrontation. It’s going to be a visible issue, very visible.”

A Labor Party?

At the August, 1981, OCAW convention, Mazzocchi introduced a resolution calling for a new national political party. It passed unanimously. He has long been one of the leading advocates within the trade union movement of a national labor party.

“I think that the opportunity for constructing a labor party is better than it has ever been,” he said emphatically, probing the air with his forefinger. “And I also think it’s a necessity—a party that at least becomes a platform for coherent expression of the nature of what’s occurring in this country. It would help draw people back across to this side of the spectrum. The right is just gobbling everybody up. Look at the responses to Reaganomics. The Democrats have been coming up with variations of the same dance.

“There is a big third party out there, the party of non-voters. It’s enormous. I think that’s an indication of people’s cynicism toward the existing political structures and choices. And for the labor movement, it means their only salvation is in a political context. It’s the only way we’re going to organize, the only way we’re going to mobilize.”

He scowled with frustration. “Right now it’s one big retreat.”

Even in a one to one conversation, it was easy to see the dynamic labor leader capable of electrifying a large audience with direct sentences, delivered with extraordinary force and conviction.

“In times of expansion it’s certainly easier to build coalitions,” he concluded, “but in times of crisis it’s necessary. The imperatives exist now. There aren’t any choices. We really have to resist what’s happening, and begin to develop offensive actions.”

Playing for keeps

After ten years of roaming around at odd jobs—supervising the Phoenix Program in a Vietnamese province, running a mail-order prayer service, assisting in tenant relocation for a condominium firm—Milton “Bear” Nuckles decided to go back to school and begin a career where he could earn a steady income. Now he describes his first year at the Hardnose School of Hospital Personnel Management in “the most engaging account of a strike-breaker’s education yet written.”

Nursing Grudges Quarterly

“A candid, eloquent, and often moving account of how one man learns to prevent union trouble.”

— Orderly Management

“Bear” Nuckles can save you a bed-pan full of money.”

— Hospital Handicapper

MEAN, ROUGH, AND TOUGH
A Touching Account of the First Year at the Hardnose School of Hospital Personnel Management by Milton “Bear” Nuckles

$4.95 Turkey Paperback

Also available

CUT COSTS, CUT FLESH: A dynamic young admissions director relates his never-ending battle to keep profit margins up at Chicago’s No. Mercy Hospital and Medical Center. Includes a special appendix: ten ways to stop the poor at the door.

Bill M. Furst $4.95 Turkey Paperback

For the best in supply sideology...

Look for the Turkey

For the TURKEY catalogue of more than 50 books on how to get rich at the expense of the poor, send $10 to cover postage, handling, and our lunch to Health/PAC, 17 Murray St., New York, N.Y. 10007. Health/PAC Bulletin subs are $15.
A Factory Life Is More Than A Living

by Tony Bale and Barbara Ehrenreich

The handmade sign on the side of the road says "WELCOME TO LONG ISLAND'S LOVE CANAL." Its carefully drawn skull and crossbones reminds anyone who might have forgotten what happened outside Niagara Falls. A second sign, more optimistic, says "HONK IF YOU SUPPORT THE STRIKING HOOKER CO. WORKERS." A young couple who look like they might be on their lunch break from one of the other factories nearby slows their car, then honks in support. Picketers on the side of the road wave back solemnly. This is central Long Island, where tract houses press up against bleak acres of industrial parkland; no one here likes Hooker Chemical Company.

The strike had support even before it started. Hooker has been dumping toxic wastes in Long Island since 1965. The Republican administration of Nassau County ignored a New York Public Interest Research Group report charging that much of the ground water in the area had been contaminated, but sales of bottled water boomed in quiet suburban towns of Syosset, Bethpage, Islip, and Hicksville. A Hooker attempt to improve its public image in the summer of 1980 backfired when local environmental activists staged a die-in at the company open house to protest its best-known unadvertised by-product, cancer.

Protests didn't really get off the ground, though, until the plant's 43 blue collar workers struck one year later over their own health and safety issues. From the collective security of the picket line, they were able to talk about what had gone on inside. Their stories surpassed the most paranoid environmentalist's suspicions. They revealed, for example, how Hooker had cleaned up for its 1980 open house: drums of toxic waste were loaded into Purolator trucks and driven around Long Island; at midnight the waste was returned to the plant. And they told how the company handled chemical spills: when 2000 gallons of styrene spilled on the ground outside the plant, management ordered the workers to simply cover it with dirt. One hot summer day the styrene burst into acrid, smokey flames.

Revelations such as these changed the character of community protest at Hooker. There were rallies, public meetings, and one August evening an innovative protest: two dozen people, mostly housewives trailing young children, marched from the main road over to Hooker's administration building, sang "This Land Is Made for You and Me," and quietly dumped their garbage out of plastic bags onto the neatly groomed lawn.

When we arrived Hooker's Hicksville plant looked like an armed camp.

"I've been saving my garbage for a week for this," said a woman who lives a few blocks from the plant, "I always wanted to dump on them." The plant security guards were too stunned to call the police. "I loved it," one of the picketing workers who had watched told us later, "I couldn't believe they actually did it."

When we arrived a few days before the "dump-in," Hooker's Hicksville plant looked like an armed camp. The bare 12 acre grounds are surrounded by a six foot chain link fence topped by two feet of barbed wire. The regular security force had been augmented with 24 rented "professionals" from an international security agency. From the road that fronts the

Tony Bale and Barbara Ehrenreich are members of the Health/PAC Editorial Board. Tony is a sociologist specializing in occupational health; he is currently teaching on Long Island at the State University of New York, Old Westbury. Barbara lives on Long Island and is the mother of two young children.
plant grounds we could see at least a dozen of them in their navy blue jump suits, high boots, and riot gear—some posted at intervals inside the fence, a cluster at the checkpoint that separates the parking lot from the plant, and two stationed on the plant roof. As we walked over to the picket line, one filmed us with a video camera.

"Don't mind the storm troopers," grinned Al (this and all other names have been changed), a short man in his early 30's wearing jeans and tee shirt with a button saying "Teamsters are beautiful." The measures Hooker and its multinational parent company, Occidental Petroleum, were taking to intimidate 43 men who earned, on the average, $6 an hour, was a source of considerable amusement for the picketers. There were 20 of them when we arrived at mid-day, white, Black, and Hispanic in proportions representative of Long Island's labor force, if not its residential population. Most of them were sitting peaceably on lawn chairs under a large, makeshift tent, trying to keep cool.

After a union organizer (Teamster Local 810) introduced us, four men offered to come over to a nearby coffee shop for an interview. By this time they had already talked about conditions inside Hooker to community groups and county health officials, but they welcomed the opportunity to get as much as possible down on tape.

"Hooker is very public relations-conscious," Al explained. Once they were back at work anyone who talked to outsiders would be risking a trip to the unemployment office.

They told us that the Hicksville plant makes a variety of what the company calls "specialty chemicals"; it also makes its employees intermittently or chronically sick. "We always knew there were problems," said Terry, "Things like rashes, headaches, coughing. We have one guy in his late 20's who coughs up blood . . . There are two men under treatment for throat cancer." He offered an explanation of how easily disasters occurred:

Four years ago when I was working with uredane I stuck my hand in a drum and pulled out two gaskets. The foreman told me to take 'em out . . . Three days later the skin peeled off my hands. Something called DMF. That's a solvent used in uredane, the most powerful one they've got. One of the fellows exposed to it had lesions all over his body.

Al described another section of the plant:

By and by we would get fever. We get sick. Sometimes, I don't know, I begin to smell wrong and what the heck, I've got to go to the bathroom and take a shower right away and remove all my clothes . . . We get the smell of that sticky stuff on our pants, the laundry won't remove it.

Terry added,

My nose bleeds and I cough up blood every time I load my reactor up. It's insufficient equipment. The mask they give up runs out in 9 1/2 minutes; and in the concentration we work in it takes 2 1/2 hours to load the reactor. We might just as well take the mask off and throw it away."

Al nodded in agreement. "I've walked into his plant when he's loading up the reactor and I walk out. I won't go up there."

Mike, who had been at Hooker longer than the others, told us that when the reactor is charged the TMA (trimalitic anhydride) concentration in the air is "anywhere from 100 to 1000 times the OSHA limit. You get rashes,
nose bleeds... it does a job on your lungs, everything."

For years, there was good reason not to complain. According to Terry, management would respond, "Well, you have a respiratory or allergy problem. We'll give you a medical discharge. Goodbye."

"That means," said Terry, "If you can't hack it, mister, get out."

No one knew much about the possible long-term effects of the chemicals they were exposed to, and they assumed that management would let them know if there was anything to worry about. "I used to clean out drums containing PVC's with my bare hands," said John, a thin, long-haired 29-year-old, "If there were cuts on my hands they wouldn't heal... I didn't know any better."

John and the other Hicksville workers began to know better when the story of the Love Canal tragedy broke. Hooker, their employer, had created it, and for the first time they heard the chemicals they worked with linked to cancer, birth defects, and chromosome damage.

"You started watching out for yourself," said Terry, "because you realized the company's not watching out for you."

But apart from minor skirmishes with management, nothing happened for several years—largely because there didn't seem to be much that anyone could do. But in March, 1981, the Hicksville workers read about a strike at the Hooker plant in Burlington, NJ.

Five of the 350 blue collar workers there had died of cancer in the space of a few years. The company had shown no interest in finding out why or in cleaning up the plant. Finally, the angry workers walked out in a wildcat strike.

Stirred by the news, 15 Hooker workers on Long Island met to discuss health and safety hazards at their own plant. They agreed to call the Burlington strike leader named in the paper and invite him out to Hicksville. Everyone pitched in $5 to pay for the gas.

Two Burlington strikers and their wives agreed to drive up and address the Hicksville Hooker's first plant-wide, rank and file meeting on health and safety issues. After hearing the Burlington story and discussing their own situation, the aroused Hicksville workers decided to affiliate with Teamster Local 810, which had helped arrange the meeting and was willing to take health issues to the bargaining table. (Although the Burlington workers ultimately lost their strike, they had set a precedent for rank and file communication between plants and across union jurisdictional lines.)

Technically, the Hicksville strike was a lockout. Management would not recognize the union and refused to discuss health and safety issues. This stance did not improve Hooker's image in the community or with its employees. In the early days of the strike, the picketers researched Hooker and Occidental Petroleum, learning a lot more about their holdings, profits, and dismal environmental and occupational record around the country. On the basis of their own experience, no horror story elsewhere was difficult to believe.

"Most of the older Hooker plants are mechanical Franksteins," Mike told us, "They were not built or engineered to produce chemical products. Here, for example, Hooker bought the plant from Inland Rubber Corporation and made a few modifications—'take this out, modify that, this pipe is still good—it's ready to fall off the ceiling but it's still hanging..."
up there—all we’ll do is change this pump, put a new line in, and so forth.’"

The consequent disasters are not surprising, Al noted. "Many of these products are transferred at very high temperature because that’s when they’re in the most viscous state. They’re blazing hot. Now the actual production kettles are old, overused. They weren’t made for continuous manufacture or for tremendous temperature changes, and we have a seven day a week production schedule, which they like because profits are at a maximum. The result is there are constantly leaks, constantly breaks.”

"And when that happens," Terry interjected, "somebody usually gets burned or you get a wide spill. It could be anything from a plasticizer to a polyester or alcohol. I’ve seen it all."

In the years leading up to the strike, there had been dozens of small confrontations over working conditions. Information was a major issue; no one knew what he was being exposed to or what it might do to him. "I fought for years to get a listing of the chemicals we use and what their toxicity rating was," Mike said.

One fluid used as a heat transfer agent was an "F-2." Nobody worried about it until migratory birds in contact with local electric power lines containing the same chemical were found to be suffering lethal birth defects. Hooker then switched to a new agent which the employees knew only as "66."

"We asked whether it’s harmful," related Phil, who had joined us in the coffee shop, "and they told us it’s not unless the vapor is heated to about 720°, and here it gets up to 450-500°, so there shouldn’t be any problem. But we don’t know if that’s true.” In the meantime, Mike put it, the vapor gets into the plant atmosphere and there have been leaks of liquid “66.”

“You have to keep asking,” Terry said, “They have the safety data sheets that are put out by the manufacturers of these chemicals. But the attitude is that you can take a monkey and offer him a banana and he’ll open a valve for you if he knows he’s going to get that banana. They say, ‘Take this and pour it in.’ I want to know what I’m pouring. To me this is just proper training, but there is no training here at all.”

He smiled grimly. "You want to know how well management knows the chemicals? We had one of the fellows mixing this stuff called TD-80. He filled the drum up with water, capped it, and walked away. It’s a good thing he did, because the drum took off like a jet and went over the top of the plant. . . . It turns out TD-80 reacts with water.”

If workers complained, they could expect management to retaliate by choosing its own "safety" issues. Mike remarked that his supervisor’s contribution to plant safety was writing him up for smoking in the boiler room. "Now there’s nothing in the boiler room except concrete, steel, and number six bunker oil, which takes a blow torch to ignite, but he caught me with a butt.” The next time Mike was written up because the boiler room was so steamy he had taken off his safety glasses to read the meters.

We asked whether OSHA had been any help, and were answered with snorts. "The last time OSHA was here was in 1978," Terry said, "Half the time when OSHA was down here we never even knew it. We were told the man was a salesman or somebody from the Jersey plant, or whatever.” Only a few weeks before our interview had they learned that they had a right to request OSHA inspections and to accompany
the inspector around the plant.

It was time to return to the picket line. Phil waved toward the desolate grounds surrounding Hooker's chemical fortress as we approached it. "I've found dead birds outside the plant. Not hurt, just dead." We wanted to know what these men thought about their own life expectancy after all they had learned, but it was not a question to ask.

"I think we're going to win," Al prophesied, "Either that or we're going to drive these bastards out of business. And when we get back inside it's going to be a whole other story."

A few days later, Hooker settled with the striking workers. One of the provisions of the agreement was a mechanism for joint worker-management surveillance of occupational hazards.

This April, months later, we asked Don Cierzniewski, former strike leader and current shop steward, how conditions had changed since the strike. "It's a better atmosphere," he assured us, "Whatever happens—spills, anything like that—they have to call the environmental agencies. You can have all the safety equipment you want, and it's possible to find out what every chemical you're working with is. For example, we had a case where a man refused to do a particular job because he didn't know what the chemicals were. If that had happened before the strike he would have been suspended."

He paused for a moment, thinking of the best way to describe the transformation. "It's a complete turnaround," he said, "We have power where before we had none."
Equipment Required
1 unloaded die
1 worker for each player
money
1 sink

Rules: Each player is given $10 in cash. Each in turn throws the die and moves his or her worker the number of spaces it indicates. The first player who reaches Retirement in good health with more than $10 in his or her pocket wins.

Workers in your plant wildcat for better health and safety. Take another turn.

The OSHA enforcement staff will be cut by over 40 percent by 1983 from the 1,697 when Reagan took office. As Business Week wrote, “the typical business establishment will see an OSHA inspector every 77 years.”

Thorne Auchter, Reagan’s new OSHA Director, bans OSHA publications and films deemed “biased” in favor of labor or alarmist about workplace hazards. Complete game with one eye closed.

The Administration sharply reduces funding for grassroots efforts of unions, COSH groups, and others to promote health and safety. Pay Rank and File $3 toward your own health and safety group and eliminate one health problem.
Union petitions for emergency temporary standards are denied for two newly discovered cancer threats, ethylene oxide and ethylene dibromide, affecting health care workers and workers handling pesticide-sprayed fruit, respectively. Your life expectancy declines. On your next turn, throw die and move backwards.

Declaring that formaldehyde is "not ripe for regulation," OSHA withdraws its name from a joint statement with the National Institute for Occupational Safety and Health warning that "formaldehyde (should) be handled as a potential occupational carcinogen and that appropriate controls be used to reduce worker exposure." You inhale while insulating walls. Sick with worry that it will cause cancer in ten years, you miss your next turn.

The Administration cancels a rule that would have guaranteed workers access to the chemical contents of trade-name substances they are exposed to on the job. Your right hand is burnt by Z-16, a mysterious new wonder chemical compound you are asked to pour. Throw die with your left hand from now on.

Your union decides to support worker health and safety committees in each plant. Take $2 from Rank and File.

OSHA is trying a "pilot program" in two regions under which employers are asked to grade inspectors on "courtesy, competence, impartiality, etc." Your inspector is fired for discourtesy after he cites an employer for a gaping hole in the plant floor. You lose one leg.

A comprehensive plan to streamline the regulation of carcinogens, developed after 2½ years of study, is suspended while "scientific and technological developments" and "cost-effectiveness" are examined for two or three years. You take leave of absence for chemotherapy. Lose your next turn.

You and fellow workers demand better goggles and get them. Pay Rank and File $5 and remove one handicap.

Your supervisor catches you inspecting your machine and accuses you of malingering. Pay Boss $5.

Your and three other workers sue management for failing to correct a hazard it knew existed. Collect double what you have contributed to Rank and File from Boss.
The Health/PAC Bulletin doesn't have to boast that it's better than the competition; there is no competition. No one else offers independent analysis of health policy issues from prenatal care to hospices for the dying; covers medical carelessness for women and on the job poisoning; offers incisive international reports and lively briefs on domestic health developments.

If you already know all this and have a subscription, why not do a friend a favor and fill in his or her name on the form below before you run out of 20¢ stamps?

Remember, nine out of ten radical doctors recommend the Health/PAC Bulletin for fast relief of health care policy mystification.

Please enter________________________________subscription(s) for the Health/PAC Bulletin (six issues)

Check: □ Individuals $15.00
□ Institutions $30.00

Name _____________________________________________________________

Address __________________________________________________________
_________________________________________________________________

City __________________________ State __________________ Zip _________

□ Bill me (plus postage and handling)

□ Charge: □ Visa □ Master Expiration date __________________________

No. __________________________Signature __________________________

Send your check or money order to Health/PAC Bulletin,

17 Murray St., New York, N.Y. 10007
Killing Us Softly

by Mark Kleiman

Last year the Reaganoids' all-out assault on social programs nearly ground to a halt on the Medicare and Medicaid front. We all may claim some credit, but entrenched health industry lobbyists provided most of the heavy mortar. Hospitals have learned how to defend their own Federal subsidies while decrying "handouts" to others.

This year the White House strategists have chosen a new approach, sniping at the margins of Medicare, underfunding the payment system, and offering states "incentives" to cut Medicaid.

A budgetary siege is planned to starve out more determined resistance. Last year hospital costs shot up 17.5 percent. Overall medical costs climbed 15 percent, bringing a two year jump of 31 percent at a time when consumer prices in general were rising "only" 20 percent. The elderly population is growing at a rate of 3.5 percent. Millions of newly unemployed workers and their families need substitutes for health insurance plans lost with their jobs. Thus if the Reagan Administration succeeds in holding expenditures at current levels or severely restricting increases, by the time we're ready to elect a new president Medicare and Medicaid will be a pathetic remnant of what they are now—which is far from perfect.

Pious statements that the Medicare budget is up $5.8 billion over last year conceal a 5.4 percent cut in real dollars. Similarly, the seemingly small cuts in Medicaid mean dramatic reductions in services—the proposed cut of $2.2 billion in the new budget on top of the previous year's $1.8 billion reduction constitute a 23 percent cutback after inflation in just two short and painful years.

For the concerned and the sadistic, a more detailed preview of this horror show follows.

Mark Kleiman is Executive Director of the Consumer Coalition for Health in Washington, D.C.
A mother with two children would be ineligible for welfare (and Medicaid) if she earned more than $130 a month in Alabama, or $126 a month in Texas.

costs to the elderly, the Administration wants to delay eligibility for new Medicare beneficiaries for up to a month and force automatic increases in Part B deductible payments.

When the elderly are staggering from these blows, they may have trouble finding a physician. By dropping a five percent ceiling on the overall rate increase doctors may charge Medicare and delaying any new charge levels three months, the budget proposal would discourage them from accepting Medicare "assignment." If they don't accept it, the Feds don't have to pay them. The patient pays, in health or in cash, but that's not the Reagan Administration's concern.

The most massive attack on hospital payments is the move to cut two percent from the "reasonable costs" hospitals can charge for treating Medicare patients. This "saving" was suggested by the profit-making hospitals through their Federation of American Hospitals in a successful effort to ward off more restrictive Federal regulation. The voluntary hospitals, organized in the American Hospital Association, aren't happy about this part of the Reagan budget at all. This disagreement is the first significant rift between the two hospital groups since they formed a coalition to oppose Federal cost containment legislation four years ago.

The voluntaries are convinced that any across the board reduction will hit them harder, since they have less privately insured patients than the for-profits and few of them possess as much sophisticated computer technology which can ferret out the most profitable rate structures. Needless to say, if this meataxe passes it will hit the public hospitals right in the neck, since they depend almost entirely on Medicare and Medicaid and also must cope with many uninsured patients.

Medicaid

Although it is billed as the poor people's medical program, only 53 percent of the country's indigent citizens (as opposed to all the undocumented aliens) are eligible for it. The Federal government pays 50-75 percent of the cost of a state's program, but each of them has broad discretion in deciding who is eligible, and for what benefits. All states except Arizona are required to enroll the "categorically needy"—those persons receiving Aid to Families with Dependent Children and some persons who are disabled. Twenty states refuse to cover any persons they are not required to under Federal law, effectively excluding the working poor. States also can (and do) limit eligibility by setting income standards extremely low. Some, mainly in the South, use so many exclusionary criteria that only 25-30 percent of those poor by Federal definition are covered.

States may also cover the "medically needy"—those earning slightly above the state eligibility ceiling whose medical expenses are so high that they would sink into poverty paying them.

To understand the Medicaid program it is important to know how low the actual poverty levels may be set. It would be nice to think that Reaganoid congresspersons who have complained about the difficulties of living on 62,000 tax dollars per year might feel a little less exploited if they knew that a mother with two

---

**Important news for 10 million Americans**

**Health Protection for Operators of VDTs/CRTs**

Find out the dangers—eyestrain, muscle pain, indigestion, stress—and some simple ways to minimize them in this booklet produced by the New York Committee for Occupational Safety and Health.

Available from Health/PAC, 17 Murray St., New York, N.Y. 10007, for $1 plus 25¢ postage for individuals and $3 plus 25¢ for institutions and corporations.
children would be ineligible for welfare (and Medicaid) if she earned more than $130 a month in Alabama, or $126 a month in Texas.

Over ten million of the nation’s 22 million Medicaid beneficiaries are poor children. Another three million are low income senior citizens who rely on the program for much of their treatment not covered by Medicare. Another four million are blind or totally disabled. All of these people, truly the truly needy, are hurt by proposed cutbacks.

There appears to be no idea so attractive to the Reaganoids as one which has failed while increasing the suffering of the poor. The Administration proposes to allow states to extract "copayments" of a few dollars each from Medicaid beneficiaries. When Reagan tried this approach as governor of California, Medicaid outpatient costs dropped a gratifying eight percent, but inpatient costs quickly leaped 17 percent as people who delayed seeking needed care became more seriously ill and required hospitalization.

What seems a "reasonable" copayment to a Reaganoid will not seem so reasonable to a mother trying to raise two children on total AFDC payments of only $60 a month—the 99 cents per day which the state of Mississippi gives poor families.

Federal Medicaid legislation once required states to cover basic inpatient and outpatient hospital services, skilled nursing homes, and physician services. Optional services each state could sign up for included drugs, eyeglasses, dental care, dentures, and prosthetic devices.

Last year Congress succumbed to the Reagan offensive against the working poor by allowing states to pick and choose which of the medically needy, if any, would be covered. States were also allowed to withhold hospital coverage from medically needy beneficiaries. This year the attack continues with a proposal to reduce the share of the tab the Feds pick up for states' medically needy Medicaid beneficiaries. States would also be deterred from covering any of the "optional" services by a three percent cut in Federal payments for such "options" as insulin for diabetics and crutches for the disabled.
Following its general human disservices pattern, the Reagan Administration strategy for Medicaid is to avoid direct cuts for which it must take responsibility, shifting the onus to the financially strapped states. White House staffers also hope that by raising the political cost of the Medicaid program, they can increase governors’ interest in a “swap” which would give them responsibility for programs such as food stamps and take Medicaid off their hands. Fortunately this fabled swap has gone to an early death this year, but we shouldn’t underestimate the Reagan Administration’s capacity to resurrect mistakes.

Opposition Bedfellows
The structure of the Congressional budget reconciliation process creates the potential for a broad, if short-lived, alliance between low-income advocates who care about care and private hospitals and doctors worried about their profits. Medicaid foots the bill for nearly 60 percent of nursing home costs and 12 percent of all hospital costs. Last year’s coalition will re-form around the same broad agreement to keep the budget “mark,” or spending target, for Medicaid as high as possible. Once Congress establishes the spending level, the coalition will once again shatter as each interest group seeks to avoid cuts to its institutions. Hospitals will stress limits on ambulatory care and may support copayments. Primary care providers and nursing homes will (privately) grouse about hospital inflation. Consumers will try to single out particularly flagrant provider fraud and urge more stringent controls as an alternative to benefit and eligibility cuts.

Although the current budget revolt offers some hope of relief, there is a strong likelihood that repeals of corporate tax breaks and cuts in military spending will be used to reduce the deficit before the money trickles down to social programs. Democratic congressional staffers recognize they will probably have to produce some set of reductions which add up to whatever money the House Budget Committee decrees health programs must surrender.

Liberals and progressives are formulating their own triage strategy. Medicare’s Part A program of hospital insurance will probably be their primary candidate for cost-cutting. They will also renew last year’s efforts to give states incentives for rational cost containment measures. Bloated payments for profit-making renal dialysis firms are another target.

Some health advocates are pushing for Federal controls on the reimbursement of hospital-based physicians such as anesthesiologists, radiologists, and pathologists. A 1981 report from the Inspector General of the Department of Health and Human Services revealed a variance of as much as 95 percent in payments for the same kinds of specialists in hospitals of the same size in the same geographic area, concluding that there was “no rational basis” for the differences. The fee-for-service and commission arrangements for these doctors provide incentives to charge as much and do as much as possible, costing Medicare alone over $1.1 billion in 1981.

Although prospects are dim for even these minimal reforms, they will be effective weapons to defend programs. Even though the health system is in many ways in worse shape than it has been since the Depression, very few advocates are actively working for comprehensive solutions which would provide decent, efficient, and accessible health care. Cautious after severe losses and grimly determined to preserve what benefits they can for poor and working people, most activists have felt a need to devote their best energies to defending the limited gains and token concessions of the 1960’s and 1970’s.

“It’s rather sad,” mused one organizer, “So many of us who fought for social change now fight so hard to defend the status quo.”

Watching the Reagan Reaction
Health/PAC is compiling a list of all projects monitoring the effects of the Reagan cutbacks. If you are part of or know of any either locally or on the national level, please let us know.
Changing the View from the Mystic River Bridge

By Matthew P. Dumont, M.D.

During the summer of 1980, drivers crossing the Mystic River Bridge were greeted by a large red and yellow sign reading; “Warning! Bridge Cleaning ahead. Close your windows.” Thick plumes rose from the surface as workers blasted away in preparation for repainting.

Although the Massachusetts Port Authority was thoughtful in warning motorists crossing New England’s largest bridge, they appeared to have forgotten about the residents of Boston’s Charlestown section and of Chelsea at either end. Living in substandard housing in the shadows of the bridge, the predominantly Hispanic population of the low income industrial city of Chelsea was unwittingly taking a perilous gamble with poison.

In 1976 I had participated in an expression of concern about flakes from the lead based paint on the bridge. Soil concentration of lead beneath it were then dangerously high, between three and four thousand parts per million — only a few parts per million is considered toxic. At the time, Massport minimized the risks of exposure but agreed to stop using lead based paint. Now, four years later, it was blithely blasting away at 25 years of regular paintings, creating a visible aerosol of lead dust.

When I spoke to them, Massport officials expressed annoyance. My inquiry, they felt, questioned the responsibility and expertise of their highly paid engineers. They informed me that enclosures around the blasting sites had been designed only after a fact-finding visit to study techniques used at the Golden Gate Bridge in San Francisco. I sympathized with the bother this trip had entailed, but pointed out that their cautionary signs for motorists would seem to indicate a certain laxity in the design.

Matthew Dumont, M.D. is a Boston-area psychiatrist and health activist.

I did have some knowledge about lead poisoning. An estimated 90 percent of the houses in Chelsea have lead on their interior surfaces. Herbert Needleman’s classic studies of the effects of low levels of body lead burden on childhood school behavior and intellectual performance were done in part in Chelsea. He found that current “safe” levels of exposure are entirely arbitrary, because there is no evident minimum level below which lead does no damage to the behavior and learning capacities of children. Lead at any level is toxic and just does not belong in the human organism.

They then insisted that there was no cause for alarm; the material coming off the bridge, felicitously called “Black Beauty,” was “99½ percent safe.” I said that may sound like a good score, but one part lead in 200 is a disastrously high level. After asking what business of mine this was anyway, they gave me a more or less polite brushoff.

I wondered how much of the madness and fury I saw every day was generated by lead poisoning.

Several years before, I had become aware of the psychological effects of marginal elevations of blood lead in adults. A 44 year old woman receiving treatment from me was suffering from a “classic case” of involutional melancholia. She had a hand-wringing agitated depression with insomnia, appetite loss, thoughts of death and delusions that her body was rotting away. The poor woman went through six months of psychiatric purgatory on top of her illness. I tried a succession of drugs. Eventually, when she was hospitalized and no longer my patient,
It was not that "evil" people became "good," but that the bureaucrats were forced to redraw their frame of reference.

She was given a course of electroconvulsive treatments by a shock mill up the river. Nothing worked and she ended up back with me. One day we were talking about anger (I am a psychiatrist after all) and she described how she was furious at her husband because he couldn't stand the fumes and dust he was creating by using a blow torch to blister and scrape paint off the walls of their house. Of course it turned out to be lead.

There is a lot of violence in Chelsea, wife beating, child abuse, adolescent mayhem. The nutrition of the people is appalling. Their calcium and iron deficient diets make them particularly vulnerable to the effects of lead. I wondered how much of the madness and fury I saw every day was generated by its poison and began routine blood lead and erythrocyte protoporphyrin tests on all our clients. Almost everyone was in the elevated but "non-toxic" range.

If you exclude perinatal complications and overt trauma or infection, it is possible that a major portion of the hyperactivity and mental retardation of children in older urban areas may be related to low level lead intoxication. And with the whirlpool of stresses of low income life, lead would have to be implicated as a source of the unusually high rates of hypertension, coronary heart disease, and renal failure among the urban poor.

So I got angry. Maybe I was lead poisoned too. I began to have midnight fantasies of putting on a black sweater and sabotaging the blasting equipment. Instead, however, I decided to find some way of working with the people of Chelsea so that they could protect themselves from the bureaucrats who were threatening their children.

Fair Share, a citizen organizing group in Massachusetts, agreed to organize some public meetings and the Greater Boston Legal Services program initiated a class action suit. The suit was dismissed when the City of Boston Lead Poison Prevention Program testified that the blasting procedure was "safe". (Politics has a noble tradition in our state.) But a lot of publicity was generated. The people of Charlestown and Chelsea grew increasingly angry at the behavior of public officials. A revelation seemed to hit many of them that they could not rely on agencies designed to protect their health, that their government lies.

Massport was getting bad press and the flakcatchers who were sent to meeting after meeting were showing signs of weariness. At one public gathering a woman carrying a baby broke down in tears while describing the repeated injections of chelating agents her daughter had to endure. When a Massport spokesman implied that her own negligence had caused the child's intoxication a man almost took a swing at him.

Massport, D.E.Q.E. and state health officials wanted to stop the noise. By the time the Federal Center for Disease Control came out with a report concluding that the blasting procedures were not safe, the Director of Massport was prepared to sign a statement agreeing to all the conditions set by the citizen's negotiation group which had been organized by Fair Share. Massport acknowledged that its procedures might subject citizens to "undue" lead exposure. (They would not accept the word "poison".) It agreed to canvass every house and factory within a hundred feet of exposure. It promised to arrange and pay for baseline blood lead determinations for each of them, and monthly redeterminations for everyone under age 17. It would identify and relocate pregnant women during the blasting periods. It would place air monitors at various points near the bridge to measure the concentration of airborne lead. An independent industrial hygienist would be empowered to suspend the blasting if air concentrations or blood lead samples reached elevations determined as hazardous by an independent body of experts. Needless to say, the fancy San Francisco enclosures would be re-designed to contain as much of the blast material as technically possible.

One conclusion which can be drawn from this experience is that a physician's anger and frustration can be directed away from his or her own stress receptors through collective action which, incidentally, can be more effective in preventing lead poisoning than any professional activity.
More interesting is the change which took place in the bureaucrats ministering to a large public authority. As time went on the agency became less defensive in confrontations with the community group and more prepared to incorporate the concerns of the people into their own cost-benefit accounting. It was not that “evil” people became “good” but that the bureaucrats were forced to redraw their frame of reference to include previously ignored second order effects. The prevention of lead poisoning became a technical problem of as much interest to them as preserving their bridge and moving traffic across it. (Maybe the inattention to second order effects is the contemporary incarnation of evil, but it does not help to think in those terms. In this case, officials of the agency seemed to turn around when a parent said to them, “I really don’t think you want to go to bed at night thinking that you may have poisoned a child”).

Even more important is the effect of these experiences on the people of Chelsea. A group of low-income and powerless people found themselves increasingly sophisticated in their understanding of a specific health problem menacing themselves and their children. They learned that they could not rely on the supposed protections of official agencies, that they had to assume responsibility themselves. When their meetings and confrontations resulted in accommodation, they experienced a sense of exhilaration, a feeling of control over events in their lives. They did not see their activism in radical political terms, but this victory could not help but give them an awareness of how collective action can affect important issues; an awareness with revolutionary implications.

Fallout

The Last Epidemic: The Medical Consequences of Nuclear Weapons and Nuclear War is a 36 minute videotape of a conference of Physicians for Social Responsibility held in San Francisco in the fall of 1980. It features Dr. H. Jack Geiger, professor of community medicine at the City College of New York. Sixteen millimeter film is also available from the Resource Center for Nonviolence, PO Box 2324, Santa Cruz, CA 95063. A transcript of the symposium can be obtained for $5.45 from Physicians for Social Responsibility, P.O. Box 144, Watertown, MA 02172.

Having seen the film and read the book, you can go to the rally and march for disarmament at Central Park on June 12, during the U.N. Special Session on Disarmament. For more information, contact the June 12 Committee, 853 Broadway, room 2109, New York, NY 10003, 212-460-8980.

Question Marx

The Summer Institute for Popular Economics will be offering four one-week sessions this summer at Hampshire College. This intensive course for minority, women, environmental, labor, and other activists will cover unemployment, inflation, the tax revolt, unions, sexism, racism, occupational health and safety, and many other economic topics.

Complete cost is $200 for low income people and $300-400 for others. Scholarships are available. For additional information and applications, write the Center for Popular Economics, P.O. Box 785, Amherst, MA 01004.

Silent Summer

Poisons and Peripheral People is a series of articles on the problems created by toxic substances for ethnic minorities and tribal societies in the Third World. Published in the last three newsletters of Cultural Survival, Inc. (11 Divinity Avenue, Cambridge, MA 02138), it describes the effects of pesticides, medicinal drugs, and industrial and mining wastes. Cultural Survival is an interdisciplinary group of academics working for the rights of indigenous peoples, mainly in South America.

Deformities of the Back

Thousands of Remarkable Cases

An old lady, 72 years of age, who suffered for many years and was absolutely helpless, found relief. A man who was helpless, unable to rise from his chair, was riding horseback and playing tennis within a year. A little child, paralyzed, was playing about the house after wearing a Philo Burt Appliance three weeks. We have successfully treated more than 50,000 cases the past 20 years.

30 Days’ Trial Free

Send For Our Free Book.
If you will describe the case it will aid us in giving you definite information.
PHILO BURT MFG. CO
66-17 Odd Fellows Temple
JAMESTOWN, N. Y.
Understanding Over-exposure
by Arthur A. Levin

One out of two Americans says "cheese" and poses for at least one medical or dental x-ray annually. In 1978 an estimated 278,000,000 radiographic examinations were given—a lot of snapshots for a national album.

Although they have little nostalgic value, these pictures offer significant diagnostic benefits—or at least some of them do. They also represent 80 percent of all exposure to human-made radiation. Estimates of how many of these pictures are medically "necessary" range from 90 percent (American College of Radiology) to 70 percent (The Bureau of Radiological Health — BRH) to 50 percent (Ralph Nader). Taking the BRH middle ground, this means at least $1.5 billion could be saved every year by tightening up medical and dental radiological practices.

If there were no health risks in low-level radiation exposure, the only concern about "unnecessary" x-rays might be their cost, but as an article in this February's Scientific American indicates, few knowledgeable people deny there is some risk that they either cause or promote cancer. The debate is over the degree of risk and how it might be quantified.

Unlike many medical technologies whose risks are not discovered until years after their invention and application, the harmful side effects of non-natural radiation exposure were all too evident almost immediately after W.K. Rontgen developed the process in 1895. Transitory injuries such as blistering of the skin appeared within hours of exposure. In less than a decade, researchers saw the connection between radiation and subsequent cancers. These pioneers in radiology were often the early victims in the years before adequate safety standards were developed. However because the radiation-associated cancers were almost always preceded by progressive skin damage, it was assumed that radiation was the culprit only when people were bombarded with doses large enough to cause gross injury.

"Even a minuscule release of radioactivity has a negative effect on public health."

It wasn't until 1950 that a scientist at Caltech, E.B. Lewis, suggested a more troubling possibility. Citing the heightened frequency of leukemia in Japanese atomic bomb survivors and in certain populations of patients who had been treated with radiation for non-cancerous conditions, he argued that no dose of radiation is completely free of carcinogenic risk.

This concept of what is called a linear, non-threshold dose-effect relationship (the less rays you're hit with, the less your risk, but you never get down to no risk) generates one of the hottest current debates in scientific literature. It was examined extensively in a series of reports from the National Academy of Science's Committee on the Biological Effects of Ionizing Radiation (BEIR)—commonly known as BEIR-I (1972), BEIR-II (1977) and BEIR-III (1979).

"In brief," a review of BEIR-III's findings in the May 18, 1979, issue of Science stated, "the majority's report says that weak radiation, in the most pessimistic estimate, is unlikely to produce effects any worse than one would expect if one simply extrapolated downward from the known effects of severe radiation. The effects decrease in proportion as dose decreases, right down to the smallest level of exposure. This means that even a minuscule release of radioactivity in a populated area has a negative effect on public health."

This moderate report was sandwiched between conclusions of a BEIR-III group which found it too alarmist because hazards in their opinion decrease very rapidly at low levels, and those of another minority which believes the linear dose-effect hypothesis underestimates low-dose risk.

Because radiation-induced cancers have no unique features, the relationship between cause and effect is hard to pinpoint even though it is generally agreed that exposure increases the frequency of most (but not all) types of cancer. There are other problematic aspects, not the least of which is the interval between exposure and the onset of cancer, often 15 to 20 years.
Epidemiological studies are therefore the basis for establishing the cause-effect relationship. In addition to the two populations studied by Lewis, workers exposed to radiation in their jobs have been examined. The greatest amount of evidence has been found by looking at leukemia and breast cancer in women. For all types of leukemia save one, incidence increases as dose exposure increases. Not only has risk from high exposure levels been identified in breast cancer, there is evidence that small doses received over time have a cumulative effect on breast tissue. Other data have been obtained from studies of thyroid cancer following radiation therapy, and of the link between prenatal exposure and childhood cancer. In workers, links have been found between exposure and leukemia; lung, skin, bone, and brain cancer; and lymphomas. Despite this clear evidence that a causal relationship exists between exposure to human-made radiation and cancer, as the 1979 Science article points out, public perceptions of various risks generally underestimate the actual danger. In rating the risk of death from 30 varied items, members of three groups surveyed placed x-rays 22nd, 17th, and 24th; their actual U.S. rank among the 30 is 9th.

The public still has to learn that x-rays can be unnecessarily dangerous to your health—even when the button is being pushed by a health provider.

The next Body English column will examine medical and dental x-rays and what can be done to reduce their number and improve their quality.

Books Received

Dally, Peter, and Joan Gomez, *Obesity and Anorexia Nervosa* (Boston, MA: Faber and Faber, 1980) $6.95
McDonald, Marian (Ed.), *For Ourselves, Our Families, and Our Future* (Boston: Red Sun Press, 1981) $4.95
Stinnett, Nick, Barbara Chesser and John DeFrain (Eds.), *Building Family Strengths* (Lincoln, NE: University of Nebraska Press, 1979)

In 1966, a Public Health Service employee came across reprints of articles published by the Federal government's Center for Disease Control in Atlanta. He found them disturbing. They described what became known as the Tuskegee Experiment. Black men with syphilis were being studied by the CDC without receiving any treatment.

The employee asked his superiors if this was an ethical medical study. Apparently the CDC still thought it was, because the experiment continued for another six years. It wasn't until 1972 that an expose in the Washington Star provoked an investigation by an ad hoc advisory panel, congressional hearings, and a national outcry which compelled its termination. Only then did the men and their surviving family members receive treatment and some financial compensation.

An experiment such as this conducted for 35 years cannot be assumed to be a fluke. It was not. As the opening chapters of Bad Blood document, in the late 19th century white physicians and white society were very eager to find proof for their conviction that Blacks were inherently inferior. When scientific medicine emerged in the early part of this century, researchers believed they had the tools to study "differences" between Blacks and whites. Discussions of different susceptibility, immunological responsiveness, and other physiological comparisons offered a scientific gloss for what more emotional observers might call blatant racist prejudice: characterizations of Blacks as innately lazy, intellectually inferior, and lacking in moral integrity.

The Tuskegee investigators ostensibly hoped to demonstrate differences in the epidemiology of syphilis in Blacks and whites. The popular view among whites at that time considered Blacks more likely to contract syphilis because of their supposed sexual promiscuity. As objective scientists, the Tuskegee research team considered themselves above such racist thoughts. However both the motivation of their study by race and its design belie this self-evaluation.

The investigators did not see the immorality of their experiment because they were blinded by the values of the health care system.

One rationalization was that the men in the experiment were no worse off than if they had been left to the care of the private health care system. This is a reasonable indictment of a market-based health care system which tends to neglect groups such as poor rural Blacks, but it is hardly a justification for deliberately withholding treatment. Besides, the book demolishes this argument by revealing that the experimenters intervened to prevent some of the men from being treated when private physicians or other public VD treatment programs discovered they had syphilis.

Jones examines in detail how individuals and a government agency supposedly committed to the treatment of disease could blindly continue a project which so contradicted this mission.

Richard Younge (Richard Younge is a family physiciant at a Federally-funded community health center and a member of the Health/PAC Editorial Board.)
## INDEX TO VOLUME 12

(September–October 1980—November–December 1981)

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>Agent Orange no. 1*</td>
</tr>
<tr>
<td>American Medical Association no. 2*</td>
</tr>
<tr>
<td>Asbestos no. 4</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>Benzene no. 1</td>
</tr>
<tr>
<td>Beta-Blockers no. 8</td>
</tr>
<tr>
<td>Block Grants no. 7</td>
</tr>
<tr>
<td>Boston, Massachusetts no. 1</td>
</tr>
<tr>
<td>Brenner, Harvey no. 3</td>
</tr>
<tr>
<td>Bronx Municipal Hospital no. 1</td>
</tr>
<tr>
<td>Brown Lung no. 6*</td>
</tr>
<tr>
<td>Budget Cuts no. 1, no. 4*, no. 5, no. 7, no. 8</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>California no. 2, no. 3*, no. 8</td>
</tr>
<tr>
<td>Cesarean Birth no. 6</td>
</tr>
<tr>
<td>Coal Miners no. 4</td>
</tr>
<tr>
<td>Committee of Interns and Residents no. 6</td>
</tr>
<tr>
<td>Community Health Centers no. 1, no. 2</td>
</tr>
<tr>
<td>Competition Model for Health Care no. 5</td>
</tr>
<tr>
<td>Consumers no. 1, no. 4</td>
</tr>
<tr>
<td>Coordinating Committee on Pesticides no. 2</td>
</tr>
<tr>
<td>Corporatization no. 2*, no. 5* no. 7, no. 8</td>
</tr>
<tr>
<td>COSH Groups no. 4</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>Deinstitutionalization no. 6</td>
</tr>
<tr>
<td>Delaware no. 4</td>
</tr>
<tr>
<td>Depo Prevera no. 8*</td>
</tr>
<tr>
<td>Detroit, Michigan no. 1, no. 2*, no. 3*, no. 7</td>
</tr>
<tr>
<td>Drummond, Dr. Hugh no. 7</td>
</tr>
<tr>
<td>DuPont no. 4</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>El Salvador no. 2</td>
</tr>
<tr>
<td>Enthoven, Alan no. 5</td>
</tr>
<tr>
<td>Eugenics no. 1*</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>Federal Regulation no. 2*, no. 4, no. 6, no. 8*</td>
</tr>
<tr>
<td>Fitchburg, Massachusetts no. 3</td>
</tr>
<tr>
<td>Formaldehyde no. 4*</td>
</tr>
<tr>
<td>Health and Hospitals Corporation no. 3, no. 6</td>
</tr>
<tr>
<td>Health Charities Reform Project no. 8*</td>
</tr>
<tr>
<td>Health Maintenance Organizations no. 6</td>
</tr>
<tr>
<td>Heritage Foundation no. 4*</td>
</tr>
<tr>
<td>Hospital Corporation of America no. 8</td>
</tr>
<tr>
<td>Hospital Closings no. 1, no. 2, no. 3, no. 7, no. 8</td>
</tr>
<tr>
<td>House, Jonathan no. 6</td>
</tr>
<tr>
<td>Hypertension no. 7, no. 8</td>
</tr>
<tr>
<td>I</td>
</tr>
<tr>
<td>International Health no. 2</td>
</tr>
<tr>
<td>K</td>
</tr>
<tr>
<td>Ku Klux Klan no. 1*</td>
</tr>
<tr>
<td>L</td>
</tr>
<tr>
<td>Lacey, Diane no. 3*</td>
</tr>
<tr>
<td>Love Canal no. 2*</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>Medi-Cal no. 8</td>
</tr>
<tr>
<td>Medicaid no. 2, no. 7, no. 8</td>
</tr>
<tr>
<td>Medical Empire no. 3*, no. 7</td>
</tr>
<tr>
<td>Medical Markets no. 1*, no. 5</td>
</tr>
<tr>
<td>Medical Schools no. 3*</td>
</tr>
<tr>
<td>Mental Health no. 3, no. 6</td>
</tr>
<tr>
<td>Midwifery no. 5</td>
</tr>
<tr>
<td>Minorities and Health no. 3*</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>Nashville, Tennessee no. 8</td>
</tr>
<tr>
<td>National Coalition to Save Public Hospitals no. 1, no. 2</td>
</tr>
<tr>
<td>National Health Insurance no. 3*</td>
</tr>
<tr>
<td>National Women's Health Network no. 8*</td>
</tr>
<tr>
<td>Neighborhood Health Centers see Community Health Centers New York Committee on Occupational Safety and Health (NYCOSH) no. 7*</td>
</tr>
<tr>
<td>Nuclear Hazards no. 3, no. 8*</td>
</tr>
<tr>
<td>Nursing no. 3, no. 8*</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>Obstetrics no. 4</td>
</tr>
<tr>
<td>Occupational Health no. 1, no. 4, no. 7*, no. 8*</td>
</tr>
<tr>
<td>Occupational Safety and Health Administration (OSHA) no. 1, no. 4, no. 7*, no. 8*</td>
</tr>
<tr>
<td>Office of Economic Opportunity (OEO) no. 1, no. 2</td>
</tr>
<tr>
<td>P</td>
</tr>
<tr>
<td>Pennsylvania no. 4</td>
</tr>
<tr>
<td>Pesticides no. 2</td>
</tr>
<tr>
<td>Pharmaceuticals no. 2*, no. 4*, no. 8</td>
</tr>
<tr>
<td>Profits in Health Care see corporatization</td>
</tr>
<tr>
<td>Public Hospitals no. 1, no. 2, no. 3, no. 6</td>
</tr>
<tr>
<td>R</td>
</tr>
<tr>
<td>Radiation no. 2</td>
</tr>
<tr>
<td>Reagan, Ronald no. 3*, no. 4*, no. 5, no. 7, no. 8</td>
</tr>
<tr>
<td>Reproductive Hazards no. 6*</td>
</tr>
<tr>
<td>Right-to-know Legislation no. 4</td>
</tr>
<tr>
<td>S</td>
</tr>
<tr>
<td>San Francisco Interns and Residents Assoc no. 3*</td>
</tr>
<tr>
<td>Social Security no. 7*</td>
</tr>
<tr>
<td>Stockman, David no. 5</td>
</tr>
<tr>
<td>Sydenham Hospital no. 3</td>
</tr>
<tr>
<td>T</td>
</tr>
<tr>
<td>Toxic Chemicals no. 2*, no. 7*</td>
</tr>
<tr>
<td>U</td>
</tr>
<tr>
<td>Ulcers no. 2*</td>
</tr>
<tr>
<td>Unemployment and Health no. 3</td>
</tr>
<tr>
<td>Unions (healthcare) no. 3, no. 6</td>
</tr>
<tr>
<td>W</td>
</tr>
<tr>
<td>Women's Health no. 3, no. 4, no. 5, no. 6, no. 8*</td>
</tr>
<tr>
<td>Workers' Compensation no. 4</td>
</tr>
</tbody>
</table>

* Short item
REAGAN CUTBACK SERIES


REAGAN HEALTH CARE CUTBACKS: A Packet of Materials on New York State and New York City. 25 pp. $2.50.

THEIR GUNS, OUR BUTTER: An anthology on Reagan Social and Health Policy. 45 pp. $3.00.


PAMPHLETS

THE PROFIT IN NON-PROFIT HOSPITALS. Illustrated pamphlet describing how profits are generated in these ostensibly non-profit institutions. 12 pp. 75¢.


CONEY ISLAND HOSPITAL: A Case Study in the Politics of Health. How one hospital is governed and how it relates to the health care needs of the community surrounding it. 16 pp. 75¢.

A COLLECTION OF DRAWINGS BY BILL PLYMPTON. American medical care as satirized by Bill Plympton in the Health/PAC Bulletin. 30 drawings, 8½” by 11” $5.00.

HEALTH CARE IS FOR PEOPLE, NOT FOR PROFIT. A 17” by 22” poster by illustrator Bill Plympton. Brown letters on beige paper overlaid on an orange fist-toll-of-dollars caduceus. See front cover. $2.50.

PACKETS

Collected back issues of the Health/PAC Bulletin covering specific topic areas. $6.00 each.

Federal Health Policy
National Health Insurance
The Demise of Public Hospitals
The Political Economy of Health
Community Health Care
The Health Work Force
Medical Education
Mental Health
Minorities and Health Care
Occupational Health
New York City Special
Consumers and Health Planning
The History of the American Health System
Ideology of Health
Women’s Health

Total Purchase $ 
Postage and Handling +
Total Order $ 

Individual Back Issues. $2.50 each. Send for an index.

Health/PAC Occasional Papers. Review articles on specific subjects. Send for an additional list.

Please fill in name and address on reverse side. All orders must be prepaid. Bulk rates available. Allow four weeks for delivery. We will send orders marked “rush” by United Parcel Service and bill you for the charge.

Health/PAC Bulletin