Chiapas, the southernmost state in Mexico, is currently the refuge of 100,000 Indian peasants who have fled Guatemala’s army, policy, and “civil patrols” of forcibly conscripted peasants. Recently the flow has slowed, deterred by 8,000 Guatemalan troops patrolling the border.

About 45,000 refugees live in the southern Pacific Coast lowlands of Chiapas near Tapachula. These people have integrated themselves into the local Mexican communities; many of them had previously been seasonal workers here. In Guatemala, most of the peasants’ small harvest goes to the rich landowners. To survive, they have supplemented their income after the growing season by working in the large coastal cotton and coffee plantations of Mexico and Guatemala. As the repression at home intensified, many decided to stay across the border with their family.

Another group of more than 50,000 lives in 71 camps in the mountains and rain forests of eastern Chiapas. This is a new area for them—in fact it was largely uninhabited before their arrival. These people are worse off because of their isolation—the majority of them must walk several days over rough jungle terrain through deep mud to the nearest point accessible to vehicles. They return carrying supplies on their backs. Worse, some of them have been targets of attacks by the Guatemalan army and air force.

I visited Chiapas in February, bringing about $5,000 worth of donated medicines and medical supplies collected by Central America Medical Aid, a Minnesota-based group. At one of the jungle camps we could reach by car, Carlotta, a resident, told her story, typical of many we heard.

In 1981 when living in Guatemala City with her husband, she went to visit her parents and brothers in her native village in rural Guatemala. One day three men from San Francisco, the neighboring village, came and said it had been attacked by the Guatemalan army. The soldiers separated the men and women, they said, and detained them in the church and the

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Island countries in the Caribbean, traditionally very poor and dependent on the fickle flow of American tourists, have discovered a wonderful new cash crop which provides a rich return with a very abbreviated growing season, little labor, and virtually no capital investment. It is also environmentally sound, since the only necessary fertilizer comes from bulls, and no foreign bodies pollute the islands' famed beaches.

This breakthrough is the sale of medical diplomas and related credentials to aspiring practitioners. Sometimes, as in the tourist trade, there is a package deal: correct answers to certification tests are included.

Although the local governments have expressed outrage at this traffic, it may be that their real attitude is more benign. After all, this new hybrid does bring in dollars, it could be considered only a slight variation of the "off-shore" medical school which inspired it, and the graduates will practice far away. Furthermore, the new variety is more resistant to the feared disease U.S. interventionism, since our government can't very well send in the Marines under the pretext of protecting students who are only there on paper.

Certainly there has been a sincere outcry here in the U.S., most anguished from organized medicine and medical education. With the possible exception of the phrase "national health service," which reduces most MD's to coloring and palpitations more commonly associated with raspberry jello, there is probably nothing which can cause American physicians more discomfort than the notion that medical education is reverting to the unregulated free market existing prior to the Flexner Report.

The medical establishment has reason to worry. Despite all the invective and railing against the instant-MD system for sullying the purity of medical education and certification, none of the media accounts seen by this writer have reported that the paper graduates have particularly harmed their patients. In fact, there have been quoted comments praising some as excellent physicians.

While this is not proof that we should sell medical degrees to all comers, it does raise the question of whether in terms of outcome—public health—there is any significant difference between the practice of these people and that of physicians with more established credentials. If there isn't, a whole host of questions about the way we organize health care demand attention.

Arthur A. Levin

Arthur A. Levin is Director of the Center for Medical Consumers and a member of the Health/PAC Board.

Letter from the Editor

To those of you who attended the First Annual Samuel Rubin Health and Social Justice Award Dinner, once again we would like to express our appreciation. To those of you who weren't able to make it to the Village Gate on May 7, we can honestly say we're sorry you missed a lovely evening.

The theme was "The Unbreakable Bond, 20 Years of Struggle for Health and Civil Rights," and the awards were given to Ruby Dee and Assemblyman Al Vann. They were richly deserved. Cora Weiss, Samuel Rubin's daughter and a well known activist herself, noted in presenting his award that Al Vann has played a major role in introducing important health legislation in New York State and conducted hearings on the causes and prevention of child abuse. As for Ruby Dee, Cora Weiss declared, "In every performance, you bring to the public's attention the pain of the poor, the potential of the neighborhood kid, the warmth and compassion of the oppressed."

But this was not just an awards dinner; it was a family gathering. There were tears in more than a few eyes as 500 people looked around and saw friends and comrades they hadn't seen in years, from the Medical Committee for Human Rights, the Committee of Interns and Residents, the Doctors Council, Physicians Forum, the National League of Nursing, the New York State Nurses Association, Nurses Network, 1199, SEIU, DC37 of AFSCME, and a whole host of local activist groups.

It would be hard to identify the highpoint of the evening. For some it was the dramatic moment when our extraordinary Master of Ceremonies, Moe Foner, Executive Secretary of the National Union of Hospital and Health Care Employees, announced that an agreement had been reached that afternoon resolving his union's internal conflict.

For others it was the tributes to Samuel Rubin—"I had thought he had just given you money," someone said afterward, "I didn't realize he participated." A number of people mentioned Robb Burlage's capsule history of the progressive health movement over the past two decades, which included a recording of a speech Al Muldovan gave to the 1965 Selma marchers on how to deal with health emergencies. People mentioned the readings by Ossie Davis and Ruby Dee. And everyone loved Sweet Honey in the Rock—if you haven't heard them live singing "More Than a Paycheck," you've missed something very special.

That evening we all—the staff, the Board, the guests—left feeling it was wonderful to be part of Health/PAC, proud of what we've done, and confident that together we can do much more.

Jon Steinberg
Health/PAC's 15th Anniversary Dinner

John Holloman

"The Unbreakable Bond", 20 Years of Struggle for Health and Civil Rights
Black Women's Health Project Update

Since last June’s First National Conference on Black Women's Health Issues the National Black Women's Health Project, Inc. has spurted ahead in both membership and activity. Over 40 self-help groups have affiliated, and new ones are joining almost weekly. The Project is incorporating, and is now a member rather than a project of its founding organization, the National Women’s Health Network. Its national headquarters, headed by Director Byllye Avery, has been joined by a fulltime office in Philadelphia run by Pam Freeman; several other regional offices are planned.

The Project newsletter is about to publish its third issue, focusing on the disease of lupus. A videotape documentary on last year’s conference will premiere in Atlanta this fall; Project radio spots on health issues are already being distributed to Black-owned stations throughout the country.

The national office has assisted local affiliates eager to start or expand self-help groups, offering single workshops or a series on “breaking through the barriers of internalized oppression” led by Lillie Allen, M.P.H. Her dynamic workshop on the realities of being black and female exhilarated over 700 women at last year’s national conference and brought invitations from groups in cities all over the country. She has also conducted sessions for Project members at both National Task Force meetings, received with similar enthusiasm.

Byllye Avery and Shay Youngblood in the Atlanta office report a surge of interest in the Project among organizations ranging from grassroots women’s groups to the Congressional Black Caucus. The Caucus has asked the Project to undertake a study on the health needs of elderly Black women in conjunction with the Morehouse School of Medicine.

“We decided to turn it around and take a look at what the quality of life for elderly Black women would be if…” says Avery, projecting a vision of a world in which they have the material and spiritual assets they need. The Black Caucus has also asked the Project to testify before Congress this September on eight key health issues affecting Black women.

Other future activities include a pilot project in three poor Georgia counties to reduce their disturbingly high infant mortality rate. The approach will be to provide prenatal care to poor women through a unique holistic (material, spiritual, emotional) “prenatal caring curriculum.”

When asked, which she frequently is, when there will be another conference like last year's, Byllye Avery replies, “Not until 1986. It took us two good years to plan the last one, and we’re not going to do it unless we do it right. In the meantime, we’re also working on a book on Black women's health issues and we’re asking all our members to contribute.”

For more information on the Project or Lillie Allen's workshops, write or call the National Black Women's Health Project; Martin Luther King, Jr. Community Center; 450 Auburn Ave., Suite 157; Atlanta, GA 30312. Tel. (404) 659-3854.

Linda Asantewaa Johnson (Linda Asantewaa Johnson is active in the New York chapter of the Black Women's Health Project.)

Power Struggle

Santayana's warning that those who do not learn from history are doomed to repeat it has a special irony for residents of the area around Three Mile Island, since they have learned but may be doomed to repeat it anyway.

Despite a 66 percent “no” vote in a 1982 referendum, the Nuclear Regulatory Commission is seriously considering allowing the "undamaged" TMI Unit I to go back on line as early as this June. This unit has an embrittled reactor vessel and damaged steam generator tubes. Local residents are well aware of this, and if the restart is permitted their well-documented stress problems are bound to increase, further undermining their health.

The NRC's willingness to permit the old TMI management, Metropolitan Edison and its parent company, General Public Utilities (GPU), to resume their role is also sure to heighten tensions. This February, the managers reached a plea agreement on federal charges for 11 counts, including falsification of records and destruction of safety data, pleading guilty to one count and no contest to six more. Although the NRC acknowledges it has evidence of rigged records, unannounced ventings, gagging of worker whistleblowers, and operators cheating on exams, it decided even before the settlement that questions of management integrity would not affect the restart decision.

The NRC does have an oversight policy: turn the other way. In the five years since the TMI accident it has initiated no long-term publicly accountable epidemiological studies. Residents' and workers' questions about health, early mortality, reproductive effects, and stress have been ignored and covered up by public and private authorities. According to the activist TMI-Public Interest Resource Center, “GPU and the Nuclear Regulatory Commission have constantly blocked studies to be conducted on the health of workers. All workers have to sign a form to release GPU from liability for health related problems now and in the future. GPU has also tried to block any independent health studies from being done on TMI area residents.”

The dangers will escalate when the 170-ton head is lifted off the damaged reactor of Unit 2. Any resulting radiation may go undetected, since the Environmental Protection Agency may remove its radiation monitors on the premise that the problems are negligible and taxpayers' money is being wasted. The "cleanup" also involves risks such as tritium in the water supply and krypton ventings—the NRC has already fined GPU for accidentally releasing krypton.
gas last fall from Unit 1, the supposedly undamaged reactor.

TMI activists believe the NRC is forging ahead with this fiasco to help the nuclear power industry redeem itself. They urge people all over the country to raise the issue and write their elected officials demanding that they ask Pennsylvania Governor Thornburgh and the NRC to respect the right to public health by preventing the TMI restart.

Copies of any letters and badly needed donations should be sent to TMI-PIRG, 1037 Maclay St., Harrisburg, PA 17102; or TMI Alert, 315 Peffer St., Harrisburg, PA 17102.

—Lin Nelson
(Lin Nelson is a freelance writer based in upstate New York.)

Kiss of Death

Over the past few decades we have become so accustomed to noting that our lipstick and crackers contain substances with strange names that often we don’t even read the small print on the package itemizing them. Our nervousness that some of them might be carcinogenic or otherwise dangerous has been assuaged by the assumption that although we might not know what guanidine carbonate and jasmine absolute are, the Food and Drug Administration and some other government agencies has ascertained that they are safe.

It appears our confidence was misplaced. A recently-completed exhaustive study by a committee of the National Research Council has found that no or inadequate toxicity data is available for 80 percent of the commercially important chemicals in commerce, 64 percent of the pesticides and inert ingredients, 74 percent of cosmetic ingredients, 61 percent of the drugs, and 80 percent of the food additives.

The problem thus is not just substances which may cause cancer. The study recommended that 75 percent of the tests for eye irritation and 40 percent of those examining human sensitivity to cosmetics chemicals be redone. Certainly rigorous testing can be very expensive and as the study notes, can require up to five years, but the authors point out that less expensive but useful alternatives exist and better ones could be developed. Several shorter-term tests used in combination could provide enhanced accuracy. More sophisticated priorities of those substances needing special attention could be established. People in specific jobs or neighborhoods could be surveyed for ill effects from exposure. Very low cost rudimentary screening tests could be developed to identify substances meriting further examination.

Government programs would facilitate all of these measures, and government regulation could demand them. The National Research Council study observed that the amount of information currently available about the different types of chemicals in general use correlates with the degree of federal regulation. Thus we know much about drugs and least about industrial chemicals.

Arms Control—the Budget

When President Reagan took office, government expenditures for research and development were divided almost exactly equally between military ($19.4 billion) and non-military ($19.6 billion) fields.

Not surprisingly, the military R & D budget has soared in tandem with the military budget as a whole. According to the National Science Foundation it was up to $32 billion in constant dollars. At the same time the allocations for all other government-supported R and D were plunging 30 percent in constant dollars to $13.7 billion.

While it may be argued that much of government research and development in health is misallocated to finding cures and technical fixes for illness which could be prevented, the cuts have been indiscriminate.

For example, the election-year budget of the Environmental Protection Agency does grant a nine percent increase, but this still leaves it nine percent below the last Carter budget. In R and D, the difference is even starker: despite a proposed 13 percent increase, the EPA would be spending 24 percent less than in 1981. Furthermore, this $33 million increase would be more than offset by slashes in the environmental research budgets of the National Oceanographic and Atmospheric Administration and the U.S. Geological Survey.

As in occupational health and safety, discrimination, and poverty, the Administration strategy appears to be the ancient Persian one of killing the messenger who brings the bad news. Unfortunately for the Persian kings, and their subjects, realities were less easily eliminated.

Film Noir

Foreign workers who slip across the border are treading on dangerous ground. Not only must they watch out for unscrupulous "coyotes" who take large sums to spirit them into the U.S., often brutal border guards, and speeding trains, once they get work it may be deadly.

Last October Michael T. MacKay, president of B.R. MacKay and Sons of Salt Lake City, and four other former officials of Film Recovery Systems in Illinois were indicted for murder by a Cook County grand jury in the death of an FRS employee. This is the first murder charge ever brought in the U.S. for an occupation-related death.

Nearly all the firm’s employees were undocumented aliens who spoke no English, according to assistant state’s attorney Jay Magnuson. Some three dozen of them have already been examined for possible acute and long-term cyanide exposure effects.

Five Mexican workers at the plant have told Magnuson’s office that the company flew them to Florida to train a new Spanish-speaking workforce. FRS also seems to have been active in other states, including Texas and Indiana. Its lucrative business was removing silver from used film and shipping it to B.R. MacKay in Utah for refining.

The Cook County state’s attorney’s office is attempting to extradite Michael T. MacKay, a request already denied once by Utah Governor Scott Matheson. Presumably Mackay is a pillar of Salt Lake City; Lot’s wife was a pillar of salt at Sodom and Gomorrah, and this is hardly a precedent worthy of emulation.

Holes in the Sponge Campaign

The new vaginal contraceptive sponge that sailed through the Food and Drug Administration approval process, onto the headlines, and into the pharmacies
The massive layoffs in other industries are finally getting closer to home and harder to ignore. Stories are running through the hospital grapevine more frequently and sounding more unbelievable. You've already formed an in-house committee to keep track, investigate, and discuss what to do about them. But despite the considerable time you've spent in meetings after working all day (or all evening or all night), things seem to have gotten worse:

A registered nurse has been fired for insubordination after refusing to be the only regularly scheduled nurse assigned to 60 patients in two units physically separated by two floors and locked doors. A licensed practical nurse has been re-assigned to nights because he refused to be available to any RN who called him to lift patients by himself. An X-ray technician with ten years experience has been fired for insubordination after refusing to expose herself to radiation by cradling infants who needed an X-ray.

People in dietary are being put on half time and asked to call in every day between 12 and 2 to find out if they're needed for the evening meal. Lab technicians are being told that they should look elsewhere if they can't work at least four hours overtime each week. Ten full time workers are being laid off in housekeeping and supervisors are telling those who are left that they will be responsible for twice as many units without any pay increase.

Your committee has almost exhausted itself trying to stay on top of the why's and wherefore's of each of these incidents when you realize that there is a pattern among them. If the committee successfully protected one of your co-workers from administrative injustices at the beginning of the week, another was in trouble by the end. Clearly, the administration's policy has been to solve its problems—whether budget cutbacks, personnel shortages, inadequate material resources, or physically dilapidated buildings and machinery—at the expense of its employees.

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You've begun to realize that despite your painstaking attention to individual problems and individual solutions, employees are still overworked, underpaid, unhappy, and alienated from their jobs, each other, and their patients. You've understood that all of these separate problems seem to be part of the same general problem—namely, that workers without power or influence are confronting a powerful and influential management and administration.

So you take the next logical step and join in organizing workers into an independent or in-house union which provides some degree of collective strength and, equally important, some measure of support, belonging, and connection.

But the administration starts giving your independent union a hard time. When you request meetings, sometimes they come, sometimes they agree to but cancel at the last minute because of a "sudden emergency," and sometimes they refuse to meet at all. In some cases, if your union or administration antipathy is especially strong, management is tying up your time, limited monies, and energies in court cases that challenge your right to exist, or to include certain groups of workers, or to speak out or negotiate on certain issues. Or it might be trying to break your new-found solidarity with attractive promotion offers to some workers, harassment of others, active recruitment of new employees (see Box 1) or aggressive media campaigns to persuade the public that your wages, rather than the profit-seeking of the medical-industrial complex, are the cause of exorbitant health care costs.

Now you're looking for outside help, more than slightly nervous because it's a safe bet the hospital administration is even less thrilled with the idea of dealing with an outside union. In 1982 the New York State Assembly's Standing Committee on Labor described the national situation when it reported that their investigations into allegations that some New York nursing homes were misusing Medicaid funds to hire "union-busting" consultants had shown that "a substantial segment of the State's health industry is anti-union and will use legal and illegal means to prevent employees from forming or joining labor unions."

Anti-union "strategy manuals" are selling briskly, including Labor Relations in Hospitals (1983) by Arthur D. and Barbara Lang Rutkowskis ("designed to help executives keep employees happier without unions") and Gordon E. Jackson's When Labor Trouble Strikes: An Action Handbook (1981), which deprecates union officials and representatives ("unwanted" and "undesired partners") as well as the labor arbitrator who tries to "second-guess management." The purpose of these books, along with many workshops and seminars well-attended by management officials, is to deny you the right to be represented by labor unions for the purpose of collective bargaining, a right guaranteed in the 1974 Amendment to the Taft-Hartley Act.

In addition to these external pressures, you and your co-workers don't think you know too much about unions. Many of the stories you've heard have been discouraging—that they take your money and do nothing for you; that they'll force you to strike even if you don't want to; that they destroy property and rough up people. How can you find out the truth?
We've developed the following check list as a helpful starting point in evaluating possible unions to join. Our rationales or reasons for including each item are summarized and relevant questions are outlined. Since you'll be making the decisions on whether or not each item is significant to you and rating them in importance, you'll probably modify this list, and may expand it.

You'll find answers by talking with union officers, organizers, and members. You might ask to see examples of contracts they've negotiated, their newspaper, other literature, educational materials, and annual reports. By talking with colleagues from other institutions and agencies; with co-workers, family and friends, you'll learn about a union's effectiveness and reputation. By joining or forming support groups with health care and hospital employees from different places, such as Nurses' Network in New York City, you'll develop ways to respond to the anxieties and questions that inevitably come up during organizing efforts.

If you listen to your administration, you'll get a fairly accurate impression of which unions, if any, it prefers. The obvious question that should follow any such "help" is "Why do these people prefer one union over another and what does that mean for me?"

**Structures and Organizations**

The strength of organized workers develops from their ability to concentrate on the common or universal conditions of their working experiences, rather than focusing on how jobs differ, at the same time that those differences are acknowledged and respected.

For instance, if a nurse leaves her friends at 11 p.m. on a Saturday night to be on a hospital unit at midnight, she spends eight hours with one or two aides who have similarly interrupted their evenings. They're more likely to understand how the other gets through the shift than they will be able to figure out what the head of nursing services does Mondays through Fridays working 9 a.m. to 5 p.m.

But because the nursing director and the nurse have had similar educational experiences with some common understandings about patient care, hold the same state RN license, and probably enjoy some of the same class privileges, they have connections that separate them from other hospital workers. These other workers, in turn, share parallel relationships with each other that exclude RN's and establish the special nature of their work and the value of their contributions.

The task of developing a collective consciousness while maintaining the integrity and uniqueness of individuals is difficult but necessary. The first questions for you as you organize are "Which connections most influence my work?" and "How do I feel about them?" Those are the relationships around which to organize. So, for example, if someone asks where you work and you answer "In a lab," it's probable that your strongest identification is as a lab technician and you'd be more satisfied in a craft union whose members are organized on the basis of having the same skill or trade or being in closely related occupations. If, however, you answer "In a hospital," and mention lab technician only after the follow-up question of "What do you do there?", it's likely you'd be happier in an industrial union where membership is organized by company or industry and according to the product produced. In our case, the product is health care or health services.
The differences between craft and industrial unions are themselves not as clear-cut today as they were earlier in this century. Nor are they as significant as the similarities between all workers. At the local level, unions often deal with the differences/similarities issue by setting up an internal structure that includes separate guilds or divisions to address the uniqueness of workers' concerns, while also providing a general organization for dealing with industry-wide issues.

The national union (often called international because many have Canadian locals) might or might not echo this structure and organization. Whether it does or not, a local's ties to a national broaden its resources, interests, and base of support.

And finally, the merger of internationals into the American Federation of Labor-Congress of Industrial Organization in 1955 was a recognition that whether they were craft (AFL) or industrial (CIO), unions had more in common with each other than not and their unity increases their potential as effective representatives of their memberships.

Questions
Does the union describe itself as craft or industrial? Is it part of a national? Which one and what do you think about it?

Who else does it represent? How are you connected? How are you different?

Does the union represent other groups in your region or is most of its membership several thousand miles away?

Where is policy made? From the local up? From the International down?

Is it a member of the AFL-CIO? If not, why not? (There have been good and bad reasons for non-affiliation.)

What is its relationship with other unions? Does it have any history of “raiding” another union's membership?

What is the union's stand on concessions or givebacks in other industries? What do they do about them?

Democracy in Action
If you're looking for a union, chances are you're already dissatisfied with working conditions and administrative policies that keep you from participating in decisions that affect your work life. Without careful attention, you might pick a union which duplicates your current experiences. It makes sense, therefore, to find out whether the one you're looking at will give you “the same old, same old” or encourage (not merely tolerate) your meaningful and influential participation.

Questions
Does the union have a structure that provides for elected delegates from each organizational unit? Do they meet on a regular basis and discuss policy and program issues?

Does the union membership have a binding vote on policy and contracts?

Are officers elected directly by the members? What are their salaries, powers, and duties?

Is there a mechanism by which elected officers must account to the membership for their actions to implement policies? For administrative changes? For financial management? For public statements?

Does the union seek and try new ways to democratize and humanize the workplace and carefully evaluate management proposals to determine whether they effect real change, are just a pretense, or attempts at co-optation or union-busting?

Perhaps most importantly, does the union allow dissent? Do delegates have an opportunity for open discussions and debate and access to the microphone? Are those with minority opinions allowed to reach the membership by printing and distributing informational literature?

Do magazines and publications express differing positions or only one “take” on any issue? What do the “Letters to the Editor” say?

Dues
Unions are financed through membership dues and any interest generated by their investment. Certain percentages of dues are allotted to the local, the national, and the AFL-CIO (if the union belongs). Any dues increase must be approved by a majority vote of the membership, according to the Landrum-Griffin Act of 1959. All basic operating expenses of the union are paid with members' monies, although specific activities or special projects are often underwritten by grants and, in some cases, gifts.

Questions
Are there any initial entrance fees and what are they? Is it a flat fee or does it vary according to earnings? Age? Skills?

What are the annual dues? How do you pay them? Monthly? Quarterly? Are they automatically withdrawn from your salary (check-off) or do you have to make payments?

Are fines levied for any reason? Why and how much? Reinstatement fees?

How does the union issue its annual financial report? Is it easy for members to get—for example, is it published in the union newspaper? Can you understand it? Does it answer all your questions on how your money will be spent?

What proportion is spent for organizing? Administration? Technical services? Financial services? Other?

How much goes to locals? Nationals?
What rights and privileges do inactive members have? Members on temporary lay-offs? Those on strike? Rehired members?

Negotiating and Servicing a Contract

A union's most visible function is collective bargaining, defined by the National Labor Relations Act of 1937 as "the performance of the mutual obligation of employers and representatives of employees to meet at reasonable times and confer in good faith with respect to wages, hours and other terms and conditions of employment..." and by others as "the struggle for power in which the parties in opposition rival and manipulate to improve and advance their own position." To deliver a contract that satisfies the members and is acceptable to the administration, negotiators must be clear on what the workers want; about what the administration is likely, might, and can give; and skilled in strategizing and anticipating reactions.

In addition, since contract negotiations take place in the real world, negotiators must be well informed on a multitude of external factors such as cost of living indices; pay benefits; trends nationally in the industry and among local and competing institutions; the local economy; the job market for hospital and health care employees; legal requirements; and more.

The issues to negotiate in a contract are numerous and varied. They include: recognition and specification of bargaining units, forms of union security, rights and duties of employers, wages, hours of work and overtime pay, vacation pay, technological changes, severance pay, grievance procedures, arbitration, seniority fringe benefits, pensions, layoff and recall procedures, sub-contracting, income security, flexibility of assignment, length of the agreement.

Once the contract has been negotiated and ratified by the rank and file, it must be administered on a day to day basis. The union has a responsibility to its membership to service...
the contract by monitoring for any violations, to use appropriate avenues to correct any discovered (see Grievance Procedures below), and to evaluate which aspects of the contract should be kept or strengthened at the next negotiations.

Questions
Ask to see some of the union’s most recent contracts. What do you think of them?

Who goes to the negotiating table? Who is considered part of the negotiating team? How much experience in negotiating do they have? Have they ever negotiated in your institution? In any place similar? For a group such as yours or one similar? Does the union currently have any workers for whom they’ve yet to deliver a contract? For how long? Why? Do workers have to pay dues before they get their first contract?

Is there any history of difficulties in winning membership ratification of contracts? Why?

How does the union monitor its existing contracts? What has the union done about contract violations? (See Grievance Procedures below).

Has the union ever been de-certified by a group it represented for either long term dissatisfaction with its negotiating or poor protection of existing contracts?

Grievance Procedures
The grievance process is your way of letting the administration know that something about your job or working conditions seems unfair or wrong to you before serious difficulties develop.

Your grievances deserve careful time and attention from your union steward; the way they’re handled by the steward and the administration will be a good clue in gauging the strength and effectiveness of the union.

Questions
Are the steps in the grievance procedure clearly written into the contract? In the employee handbook? Do you understand them?

Who do you grieve to? How? Who will represent you at which steps? Stewards? Union grievance committees? National union committees?

Is there any history of these representatives discouraging grievances?

Are there any time limits stated? How long after your complaint must the process formally begin? How long will the decision take? What about an appeal?

Does the union have a history of settling (not necessarily winning) grievances at early stages? Do they get blown up? Does it clearly identify the real issues?

Do discharges, suspensions, or other disciplinary actions get priority?

Does the union handle all complaints or only those covered by contracts?

Is there immunity for the worker who grieves? Is there pay for time taken for the grievance process?

Enough Full-Time Organizers
“Once the union knocks, the employer’s best strategy is to defeat the union organizing campaign during its inception,” according to a leading manual for “union busters.”

Since this sentiment is becoming an administrative maxim, the organizing campaign will be the time when any of your fears about administrative pressures or harassment are most likely to be realized. You’ll need someone who knows an “unfair labor practice” when he or she sees one, who can explain what you and the administration can and cannot do legally; someone who can answer questions, calm panic, and counter scare tactics; someone who organizes meetings and activities properly to encourage and share information with all the employees.

Questions
How many organizers is the union willing to assign to your institution or agency?

Will they come to you at convenient times? How often? How long are their meetings with you? Do they rush off?

Are they easily available by phone? Do they return your calls promptly?

Do you understand what they’re saying? Do they take the time to answer questions fully or speed-talk you into confusion?

Do you think they know what they’re talking about? Do they understand your job? Your institution? You?

Willingness and Ability to Support a Strike
In encountering administrative representatives of hospitals, nursing homes, medical-industrial empires or health care corporations, you are facing the frontmen/women of a multi-billion dollar industry. The stakes—the redistribution of control in the workplace—are high, and the administration’s resources are extensive and seemingly overwhelming—except for one thing. The industry’s profits and management’s profits at your institution or agency depend on maintaining at least the appearance that health care is being provided. Since your collective willingness to work or withhold your labor determines whether the industry’s products are delivered, your bargaining power is potentially tremendous.

For a variety of reasons, some union leaderships have been resistant to strikes. For example, until recently some public sector unions and state nurses associations have questioned the ethics of strikes at health care institutions. Others have disagreed with their membership as to whether or not a strike would be effective in particular cases. Others have been criticized for being more concerned with giving management a stable labor force and keeping labor peace than with the grievances of their members.

Nonetheless, workers in increasing numbers have initiated and sustained strikes with or without leadership support.

Questions
Are there formal rules for calling a strike? What are they? How is a strike called off?

Who goes on strike? Units? Guilds or divisions? Entire locals?

If no fund has been established, how will money be raised?

Questions
Are a strike benefit fund already set up? What are the rules for collecting money? How much? For how long?

On what issues has the union struck in the past? Do they call strikes frequently or hardly at all? How is picketing conducted? Are union officers on the line? For how long?

What have these strikes gained? Lost?

Is there any history of “wildcat” strikes among workers they represent?

Usual Benefit Packages
Benefits have been considered earned compensation (pay)
for a long time. Currently workers in many industries are being asked, in some cases forced, to "give back" benefits they've previously earned and negotiated. At the same time, executives in the same industry often enjoy compensation packages that include bonuses and stock options worth hundreds of thousands of dollars above their already generous base salaries, as well as a variety of "perks" such as elaborate exercise/fitness centers, discounted business travel, company help in finding housing and arranging mortgage rates, expense accounts, reimbursement for educational expenses, etc. (See Boxes).

It's a pleasurable fantasy, but an unlikely one, that such favors will filter down from the administration to the organization's labor force or that unions are in any position to win equal advantages for their members. Nonetheless, you have a right to expect that your representatives will negotiate the best possible package for you and your families in areas such as health insurance, death and disability benefits, retirement plans, savings and capital accumulation plans, unemployment pay, vacation pay and holiday time, and educational assistance.

Questions

1. Health Insurance. Who pays for it? You? Your employer? The union? If you all contribute, how much comes from each? Is there one plan for everyone? If there's a base plan and a supplemental plan, what does each cover? Do your choices include enrolling in a Health Maintenance Organization (HMO)? What differences are there for different age groups? Single vs. married? With dependents? How many?

What is the deductible expense, i.e. how much will you have to pay out of pocket before you're eligible for reimbursement? Do you have to pay a percentage of all bills above that? Is there a maximum amount covered for each service or are they covered fully? If there's a maximum, is it high enough to help you significantly?


2. Disability. Do you have to contribute out of your weekly paychecks or is it covered by your employer? Your union? How much money does the program provide? For how long? How long do you have to work or be a union member before you qualify? Is there insurance for a non-work-related accident or sickness that causes disability?

3. Death. Does your death insurance depend on your salary or is it uniform for all workers? Is there a base plan and a supplemental?

What does it provide for your family? What if you've retired?

4. Retirement Income and Capital Accumulation Plan. Is there a fixed pension plan or does it depend on your seniority and/or earnings? Do the company and the union contribute to it? Does early retirement affect it? Is it transferable to your spouse or dependents?

Is there a savings plan? Through payroll deductions or our deposits? Are there any special interest rates? Does the company have to contribute? Are there qualified trust funds? If so, where do these funds invest your money?

If your hospital or agency is part of a proprietary corporation, is there any profit-sharing? Current payout or deferred distribution? Are there opportunities for acquiring stock?

Reduced broker's commissions? Is there a Monthly Investment Plan?

5. Time Off With Pay. Full pay or partial? How much vacation time for new employees? After five years? After ten?

How many holidays are recognized and which ones? What about religious observances? Any personal days? What if someone in your family or a close friend dies? Is there time off for jury duty? Military duty? Civil emergencies?

6. Pay for Unemployment. Is there any plan for getting paid if you're temporarily laid off? For how long? How much?

7. Educational Assistance. Does the union or the hospital offer any tuition reimbursement? For your dependents? Educational leaves?

Will it help you upgrade your skills? Does it offer any workshops with continuing education credit?

Occupational Safety and Health

While you're exhausting yourself caring for patients with limited personnel and inadequate supplies, administrative policies are often undermining your health through benign neglect or overt callousness.

The Occupational Safety and Health Act of 1970 gives hospital and health care employees the same legal rights as all other workers to "safe and healthful working conditions." Given the hazards of hospital work, union actions to help you secure your rights and preserve your own health and that of your families and friends are vital.
The threat of occupationally-related illness and injury is an equalizer among all hospital and health care employees. In the common working environment each is exposed to infection, stress, radiation and high energy, chemical hazards, biomechanical trauma (e.g. back strain), and safety hazards. Depending on where in the institution you work, you might also be exposed to health hazards such as ethylene oxide, formaldehyde, antineoplastic drugs, methyl methacrylate, and anesthesia gases.

Questions
Does the union have a health and safety department? How well is it staffed? Does it offer educational programs to its membership? Help in setting up in-house health and safety committees?

Does the union include specific clauses in its contracts that guarantee safe and healthy working conditions? If not, does it use the grievance process to protect your health?

Does the union keep health records over a long enough period (20 or more years) to detect patterns of disease and death among its membership? Do they review the records on a systematic basis? What have they found? What do they do about it?

Does the union safeguard the workers’ “Right-to-Know” what chemicals they’re exposed to in the course of their work? Does it lobby for legislation in those states without such protection? Does it work with local Committees/Coalitions on Occupational Safety and Health (COSH’s)?

National Policies and Social Issues
American working people pay for, and do the fighting and dying for, our powerful military-industrial complex. Among its activities have been the destruction of Vietnam and Cambodia, the invasion of Grenada, and “covert” military operations such as the mining of Nicaragua’s harbors. Its policies help perpetuate and accelerate the dangerous and wasteful arms race with the Soviet Union.

Military expenditures make up a massive and rapidly increasing share of our national budget while an increasing number of people, most of them women and children, are “starving in the land of plenty,” without jobs or hope of finding them, and without access to health and human services.

The effects of the current Administration’s policies have been extensively documented by Health/PAC and other organizations. Many of them are evident to most of us, even if government officials profess to believe that some people stand in soup kitchen lines or live in crowded homes because they like to. In its recent report, “Inequalities of Sacrifice,” the Coalition on Women and the Budget confirmed the general impression that the rhetoric of reducing federal spending was only a smokescreen to cover a policy of gutting some programs while expanding others. For every $1 taken from poverty programs, for example, the military has received $4.15.

When anyone asks you how this affects your work, you can tell them plenty about how national policies are damaging people’s lives and your own work experience. If you work in a hospital which serves poor and working people, you know the patients who manage to get there are sicker when they arrive and either stay longer or are still sick when they leave. The mothers who visit your clinic tell you that their children get less to eat, less to learn, less chance to be healthy. They also say that their husbands and sons seem to drink more and are angrier and more abusive since being out of work. You’re being asked to do more things in the same or shorter amounts of time for the same pay, but figure you’re lucky because many of your friends have lost their jobs.

Questions
Does the union monitor the direct effects of governmental policies on the working experiences of its members? For example, does it keep track of how the new DRG system is affecting the workload and work schedules of hospital employees? Does it keep its membership informed of what it finds out?

Does the union exert its leadership and influence to speak out against U.S. interference in other countries in defense of a rich minority opposed by the overwhelming majority of the population? Does it speak and work against racial, class, and sexual discrimination in society as a whole and in the health care system? Against the corporate takeover of health care?

Does the union support the movement for a nuclear freeze? For a more equitable distribution of the nation’s wealth? For protection of our environment?

Women’s Issues
Women make up 76 percent of the health labor force; most of them are burdened with the added stress of societal expectations that they also maintain a home and family. In some occupations, the nursing, for example, as much as 96.4 percent of all workers are women. Their work involves the institu-
tionalization of “traditional” female activities, caring for the sick and managing births, and serves as a metaphor for “tradi-
tional” maternal roles such as nurturing and comforting. For
these reasons, health care is usually seen as women’s work, and
whatever value a society places on women’s work in general will be carried over to health care, whether it is ac-
tually performed by women or by men. In addition, patients
are more likely to be women than men, so their concerns are a large part of a health worker’s job.

Questions

Does the leadership of the union reflect its predominantly female membership?

Does it demand comparable worth provisions in its contracts and move to redress existing inequities?

Does it refuse to support political candidates who do not have a strong ERA platform? Does it speak out in support of reproductive rights? For government aid programs like supplemental food for women and children (WIC)?

Does it monitor the availability and quality of women’s health services? What does it do about sterilization abuse of both health care consumers in general and its membership? About other assaults on women’s bodies such as unnecessary or ex-
cessive surgery and the overprescription of medications?

Does it work for free, quality daycare for all women? Pro-
vide child care at its meetings, conferences, and events? Do its workshops reflect women’s concerns?

A Final Note: Beware of those who wave figures in front of you that “prove” the decline of trade unions. Beware of those who blame the high cost of health care on union demands for higher wages while ignoring the expense of technology and the profits of hospitals, medical suppliers, and pharmaceutical corporations. And beware of those who try to convince you that you’re better off on your own without any association, organization, or union.

These arguments are pushed by people who prefer to deal with individuals rather than organized workers. You can guess why. Of the options available to hospital and health care employees, unions continue to hold the best promise for transforming your work into humane and caring experiences, for you and the patients you serve.

5. Stern, op. cit.

Books Received

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Older, Julia, Endometriosis (New York: Charles Scribner’s Sons, 1984) $15.95

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Have Housestaff Found a Home?

by Edward P. Ott and Gilda Zwerman

This is the fiftieth anniversary of the housestaff movement in the United States. Since its inception, the movement's goal has been to organize salaried physicians—primarily interns, residents, and hospital fellows—to improve wages, working conditions, and patient care, as well as to provide a unified voice on social and political issues.

Even among its members, reaching the half century mark has attracted little attention. When Terry Fitzgerald, M.D., president of the New York-New Jersey Committee of Interns and Residents—the largest housestaff organization in the country—mentioned it in his opening remarks at the Conference of Housestaff Organizations held this April 27-29 at CIR headquarters, there was no applause and virtually no interest.

This lack of fanfare reflects the uniqueness of a union with a membership turnover of virtually 100 percent every three to five years. The result is a tendency toward historical amnesia among members, organizational instability, and inexperienced leadership whose “inheritance” amounts to an uninviting pile of archival leaflets, resolutions, and bylaws.

In this context the movement's ability to sustain itself, with varying degrees of success, since 1934 is itself a considerable achievement, and its nascent stage of development at middle age is not surprising. Primarily concentrated in urban hospitals, the movement currently boasts strong local organizations in New York, Boston, Los Angeles, and Chicago. However even in these cities winning formal recognition from the hospital administration, the National Labor Relations Board, the labor movement, and a substantial proportion of the doctors themselves has been a formidable task. The most common obstacle has been the argument that housestaff are students or employees in transition, and therefore not entitled to collective bargaining or unions.

This is a past the conferees were eager to transcend, and many were optimistic that they soon will be able to. Most of their well-ordered, thoughtful discussions concerned the related topics of the need for a national organization and how to organize interns and residents in public and private facilities.

The New Federation

The idea of forming a national organization is not new. In 1971, the National Housestaff Coalition, a loose grouping of about 10,000 active housestaff, voted to establish the Physicians National Housestaff Association. During the mid-1970's the PNHA organized job actions on the issues of patient care and salary grievances, but its efforts soon foundered. The few large, stable chapters were unhappy carrying the financial burden while the smaller chapters were devoting all of their resources to organizing on the local level. The loss of a court battle to gain NLRB recognition as a union was a heavy blow, and PNHA officially dissolved in 1979 after CIR withdrew.

Renewed interest in forming a national organization has been sparked by recent developments in California. For the past six years, the housestaff of the University of California have been trying to organize in the face of administration objections that they are students, not employees. But this time the union position has been sustained, in a February 1983 ruling by the California Public Employee Relations Board. The University has appealed, but most observers expect that decision will be upheld by the California Appeals Court this fall. If so, there would be a housestaff vote throughout the entire University of California system. This election, involving 4,500 housestaff physicians, would be the largest of its type ever held in the United States.

The likelihood of a fiercely contested vote in the near future created a sense of urgency at the April meeting in New York. When Alan Brill, an organizer from San Francisco, told the delegates that the California Association of Interns and Residents wants to organize “in conjunction with a national organization,” his message was that CAIR might be forced to affiliate with some other national union.

“Are we going to have an organization run by housestaff,” he challenged the other delegates, “or a series of housestaff organizations affiliated with many different unions?” CAIR feels that the backing of a national organization is essential for the state-wide vote since the University will use its considerable resources to resist housestaff organizing efforts and CAIR’s own resources are no match for them.

In the protracted discussion that followed, the delegates from Boston expressed reluctance to commit themselves to any national organization but indicated that they wanted to support the efforts of California housestaff. Jonathan House, M.D., Executive Director of New York-New Jersey CIR, favored a national organization but warned that “talk of a national organization raises anxieties based on past experience and rational fears. There is a danger of creating a minimally effective but maximally costly bureaucracy.”

Just before the vote was taken, CIR President Fitzgerald pointed out that “Any single group could face a crisis that might require the support of a national structure. We should have

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a structure in place before a crisis sets in." The delegates agreed; on Sunday morning they issued a call for the creation of a National Federation of Housestaff Organizations uniting local groups that engage in collective bargaining on behalf of interns, residents, and fellows.

A resolution released the week of April 30 affirms that the new National Federation intends to safeguard the movement's historical commitments to local chapter autonomy, quality patient care, and the betterment of working conditions for housestaff physicians.

Troubles Ahead

The efforts of housestaff to link the issues of quality patient care and the quality of working conditions for physicians promises to become more difficult as the trend toward subcontracting of medical services accelerates. Tasks once performed by hired staff of a hospital are increasingly being farmed out to private companies which provide their own equipment and use it to service several hospitals.

For the hospital, this means release from the financial burdens of buying and maintaining equipment and paying health and pension benefits to many employees—the subcontractors generally hire on a temporary basis, pay low wages, and give almost no benefits to their employees, often hispanics, blacks, or recent immigrants desperate for jobs and willing to work under substandard conditions.

Hospital administrators have made subcontracting an integral part of their comprehensive strategies to maximize cost-effectiveness. They believe it has worked well in their service and maintenance units and should be extended to functions performed by housestaff physicians. If pushed to its limits, subcontracting will divide and decentralize all hospital employees, including housestaff, making union organizing harder than ever. Furthermore, as service and employee contracting out surges, hospital employees, unions, and consumer groups will find it increasingly difficult to monitor standards and maintain quality control over health services.

Can the Federation Succeed?

The housestaff movement and the issues raised at the 1984 Conference highlight some of the major concerns of a relatively small, politically aware group of healthcare professionals. This does not, however, tell us whether these issues are on the agenda of salaried physicians as a whole.

While union membership among industrial workers has declined since World War II, unionization has been up among highly skilled professionals such as physicians, college teachers, and lawyers. Many skeptics believe this trend is insignificant within the overall picture of labor politics. Some scoff that unionization among doctors is merely an attempt by members of an already overpaid occupation to secure even greater economic benefits. Others belittle it as a political aberration, a last-ditch attempt by erstwhile 60's radicals to maintain a semblance of activism in their new profession.

One skeptic, Rep. Major Owens, member of the House Committee on Labor, was the keynote speaker at the 1984 Housestaff Association Conference. You're committed, ethical people, he told the assembled housestaff officers, "And I love you for it." Yet doctors, he went on to say, "are part of the system. A system that is greedy. A system that excludes large sections of the population from access to decent medical care. A system that is committed to profits, not people."

Are those interns and residents active in the housestaff movement really as exceptional as the skeptics say? Clearly the conference delegates don't think so. Their resolution launching the National Federation emerges from a consensus among the
housestaff movement leadership that growing numbers of physicians will share their enthusiasm for a doctors' union, embracing it as an appropriate representative of their interests as professionals as well as employees.

At present, however, most physicians in this country do not think they are in need of a protective labor organization. Many, through their membership in and identification with professional organizations such as the American Medical Association, are committed to resisting corporate and management authority in hospitals in ways that do not involve collective bargaining or development of a trade union consciousness. Their self image is members of an elite occupation, untouched by the external authorities in society.

Medical training and the orientation of the American Medical Association socialize physicians into believing that they are the dominant force in the health care industry. This notion is founded on two assumptions. First, that doctors are autonomous in a hospital setting, with the power to determine standards of practice and working conditions. Second, that employment in a hospital is part of a training process that will propel most of them toward a lucrative private practice.

The reality is otherwise. Current employment figures show that about 300,000 doctors in the United States, over 40 percent of those currently in practice, are employed by health maintenance organizations (HMO's), the federal government, hospitals, and clinics. According to Dr. Jonathan House, "As health care is increasingly delivered out of large corporate entities, there will be more and more salaried physicians. The proportion is expected to grow to 70 or 80 percent in the next ten to 15 years."

In this context, the new National Federation has a vast potential constituency, but it faces an extremely complex task. Foremost, it will have to clarify the distinction between its support for *job control and work autonomy* for physicians and the American Medical Association's longstanding insistence upon a *monopoly of control* for physicians at the expense of other health care employees. In addition, the Federation will have to prove to the labor movement as a whole that a union of professionals dedicated to both physicians rights and patients rights is essential to the development of a rational system of health care delivery in the U.S. Persuading Americans that the housestaff organizing slogan "low wages is bad medicine" is more than self-serving will be a long struggle.

jail. After they looted the village, they took the women out and shot them in groups of 20. Their bodies were burned and disembowelled the children and threw them, some still alive, in a pile inside a house. Finally they took the men in groups of ten, tied them up, threw them on the ground, and shot them. When 25 men were left in the jail the soldiers set it afire and moved away. Six men escaped out a window; three of them were shot. The other three, who made their way to Carlotta's village, were the only survivors from a village of 300 people.

After hearing this story, Carlotta's entire village fled terrified into the jungle, leaving their homes, crops, food, and animals, and made their way to Mexico with only the clothes on their backs. The trip took many days. Some people died, and the remainder arrived in Chiapas exhausted, half-starved, and sick. Carlotta hasn't seen her husband since.

We were able to visit two camps near the Montebello lakes in the Chiapas highlands, Cuatemoc (1100 inhabitants) and Benito Juarez (625 inhabitants). Living conditions are severe in both. Families live in closely-spaced huts about ten by 12 feet, windowless, with dirt floors, walls of strung-together stakes and roofs of heavy corrugated tin paper. They offer little protection from the cold and have no electricity or running water. Cooking is done in the center of the hut over an open fire, which is also the source of heat. Exposure to smoke combined with the cold in the huts contributes to the significant amount of respiratory illness. Between and immediately around the dwellings there is no greenery, only packed dirt.

Most of the trees around the camps have been cut for fuel and lumber, so the refugees must carry wood long distances over the denuded hillsides. There is scant evidence of cultivated land; we were told the Mexicans do not allow the refugees to farm around these camps since they are nervous about the strain it will put on the local economy and fear the refugees will settle permanently. The absence of farming contributes directly to a food crisis, despite some help from relief organizations. The only animals people have are a few chickens. The people are hungry.

Dr. Jose Carrillo, a Mexican physician, works with the refugees for the Catholic Church. He has practiced in Nicaragua, and holds a degree in public health from Cuba. According to two studies he has done of disease and malnutrition in the camps, one third to one half of the refugees need health care services every month. The most common problems are acute bronchitis, parasitic infections, malnutrition, and severe anemia. Seven out of ten children suffer some degree of malnutrition. One of ten malnourished children may weigh only half as much as a well-nourished child of the same age. Nine of ten malnourished children suffer from illness, mainly infections of the lungs or intestines.

Relief aid comes from several sources. COMAR, the Mexican government agency with jurisdiction over the refugees, has a budget of $6 million. Its responsibilities include services; supplying food, clothing, and medicine; and coordinating the relief work of the Catholic Church and other agencies.

The Church is a major source of support for both the Guatemalans and the local Mexicans, many of whom are as poor as the refugees. It has a budget of $1.5 million for supplies and development projects in education, agriculture, and cooperatives. An independent local organization, CARGUA, also provides help. Half its $100,000 budget goes for food, and the balance for projects in nutrition, health, and animal husbandry.

Despite the significant efforts of these relief agencies much of the need is still unmet. We brought medicine and supplies to workers from the Church and CARGUA, and to the state hospital in Comitan, 60 miles from the border. The hospital is a 60-bed facility accommodating 100 patients, one third to one half of whom are refugees. Diseases resulting mainly from malnutrition, poor sanitation, and a generally inadequate living environment are prevalent, among them tuberculosis, bacterial and parasitic infections, and anemia. Funding from UNICEF enables the hospital to maintain two nourishment centers for children, where care is also given for measles, polio, whooping cough, and other childhood diseases which can be prevented with immunization.

The conditions of Guatemalan refugees in Mexico is desperate, but they are more fortunate than many of their compatriots still in their own country. A priest in Chiapas gave me documents concerning the displaced persons in Guatemala, approximately half a million in a nation of 7.5 million people. They are of the rural poor, who have been trying to organize to improve their lives. The army and security forces have responded to this challenge to the wealthy landowners by terrorizing the peasants out of their villages into the remote mountains, from the country to the city (especially Guatemala City), and from the north to the south. Those who have fled to the mountains often lack food, clothing, shelter, and medicine. Relief assistance is minimal. Many are starving and freezing to death.

The Guatemalan Human Rights Commission, a member of the International Federation for the Rights of Man, circulates a Monthly Report of Repression in Guatemala from its headquarters in Mexico City. This report documents names, ages, occupations, circumstances, and in some cases photographs of victims of violations for the previous month, chilling testimony to the repression. The incidents are broken down into assassinations, kidnappings, disappearances, and other repressive acts.

U.S. support of repressive governments and military intervention in Central America must be stopped. All of us must try to influence our representatives to change our government's foreign policy, to permit freedom and self-determination. And we must continue to send money and supplies to the people suffering in the wars there. Contributions can be sent to Central America Medical Aid, P.O. Box 8868, Minneapolis, MN 55408.

Josh Lipsman
Minneapolis, MN

Since Josh Lipsman's visit the Mexican government has begun forcibly removing refugees from the border areas. Officials say that frequent land and air incursions, culminating in an April 30 attack in which soldiers in Guatemalan uniforms killed six refugees, show that the border camps cannot be protected.

Several thousand Guatemalans have already fled into the night to avoid removal. The Church has reiterated its earlier offer of land for them. The government has so far been adamant in pursuing its plan.
Health care has become a spawning ground for a growing number of millionaires and for a select few holders of even more substantial fortunes. These people are the big winners in a health care system shaped increasingly to facilitate the accumulation of personal wealth.

The health rich and super-rich are generally not known to the health care community. Rather, their exploits are celebrated in the business press, with its lists of the biggest and fastest-growing companies, and the highest paid and wealthiest individuals.

These people are also worthy of the attention of anyone concerned with health care. Knowing who they are and something about how they became so extraordinarily rich provides a basis for understanding how wealth is amassed through the provision of drugs, medical supplies, diagnostic equipment, health services, exercise and nutritional accoutrements, and the other commodities that together generate the product "health" in the United States.

The chief executive officer of a large corporation in the health care industry receives a generous salary, but needs substantial stock holdings to enter the higher circles. Edmund Pratt, Jr., CEO of Pfizer, received an impressive $887,000 in salary and bonus, but this put him only fifth of 16 on the *Forbes* list for pharmaceutical firms. On top was Donald Rumsfeld, Secretary of Defense under President Ford, Middle East envoy under Ronald Reagan, and currently chief executive of G.D. Searle. His $833,000 in salary and bonus income last year was supplemented by $101,000 in other compensation and $481,000 from stock, for a total of $1,415,000.

Hospital management companies paid their top executives comparable amounts. Thus Royce Diener of American Medical International earned $788,000 in salary and bonus income and another $196,000 from stock.

It is often argued that such colossal salaries are needed to spur executives on so that the whole world can benefit from their frenetic search for corporate growth and profits. However this argument is belied by ServiceMaster Industries of Downers Grove, Illinois. A religiously-oriented company, it contracts with hospitals to provide housekeeping, laundry, maintenance, and food preparation services. Over the past ten years, ServiceMaster has provided the highest return on stockholder equity of any of the *Fortune* 500 service companies or 500 leading industrials. Yet in 1983 the company's CEO received $175,000 in salary as his full compensation; this put him tenth and last on the *Forbes* medical equipment and services list, with just a little over half the salary of the ninth place finisher.

Even those earning over $1 million a year are not the big earners. Becoming an entrepreneur and major stockholder in your own company is the route to a truly substantial fortune. One who did is Richard Eamer, founder and chief executive of National Medical Enterprises, one of the largest and most diversified of the for-profit hospital companies. In 1982, a good year for the stock market, Eamer made $415,000 in salary, $260,000 in bonus income, and another $2,047,000 in long-term gains on his stock. In 1983 Eamer's salary and bonus income jumped to $1,104,000. At the end of the year his stock holdings were worth over $14 million.

Vast as the HCA and Humana fortunes are, they do not approach the super-rich category.

Dr. Thomas Frist, Jr. is currently head of the largest for-profit hospital company, Hospital Corporation of America, based in Nashville, TN; he founded HCA in 1969 with his father. In 1983 his total compensation came to $1,404,000; his stock holdings were in the neighborhood of $25 million. Since his father held an additional $16 million worth, the family fortune was well on the way to sizeable. David Jones, founder and CEO of Humana, the number two company, has moved into the same financial neighborhood.

Vast as these fortunes are, they do not approach the super-rich category. This can be made by an entrepreneur who takes a substantial privately-held company public or sells out to a corporate giant. One of 1983's biggest financial success stories was Leonard Abramson of Willow Creek, PA. Abramson's U.S. Health Care Systems health maintenance organization (HMO) started out in the mid-70's with a federal grant and a Health and Human Services loan. In 1981 he converted his creation into a for-profit firm, sold a 40 percent interest to Warburg Pincus Capital Corp. of New York, and used this venture capital investment to help repay the government loan and expand the business. U.S. Health Care Systems went public

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in February 1983; Abramson's stock was then worth $31 million. Riding the crest of speculation that for-profit HMO's will be the next big money-maker in the industry, U.S. Health Care's stock rose 139 percent by the end of the year, putting its founder in the top rank of paper earners for 1983.

Abraham Gosman of Newton, MA took his Mediplex Group public in October 1983, and became the holder of $40 million in stock. Mediplex specializes in nursing homes, and alcoholism and drug rehabilitation centers.

The most spectacular financial gain in the health industry last year belonged to the principals in Diasonics, Inc., of Milpitas, CA, makers of diagnostic imaging equipment. The top three executives and an investor realized paper gains of $274 million the day the company went public. Chairman Arthur Rock's $84 million share, while the highest in the health industry in 1983, was dwarfed by his Silicon Valley neighbor K. Philip Hwang's stunning $520 million instant paper fortune when his Televideo Systems went public. Nevertheless venture capitalist Rock's total investments gave him a minimum net worth of $160 million, enough to place him comfortably on the Forbes 400 richest list for 1983. (Since then Diasonic's stock has plunged, so he may not make the 1984 list.)

Other new-rich health care entrepreneurs among the Forbes 400 include:
- William Fickling, Jr., founder of the Charter Medical Corporation of Macon, GA, a hospital management company (estimated minimum worth: $140 million)
- Dermatologist-inventor Philip Frost, co-founder of Key Pharmaceuticals (estimated minimum worth: $150 million)
- Frost's partner, Michael Jaharis, Jr. (estimated minimum worth: $125 million)
- Medical school dropout turned Mormon missionary James Sorenson. His medical device company was bought by Abbott Labs in 1980 for $100 million (estimated minimum worth 1983: $200 million)
- Edwin Whitehead of Greenwich, CT, principal owner of Technicon Corporation, specializing in blood analyzers (estimated minimum worth: $150)
- Ewing Kauffman of Kansas City, MO, a former pharmaceutical sales representative made his Marion Laboratories into a millionaire manufacturer. Kauffman claims that stock-sharing in the firm, which specializes in marketing foreign drugs and doing research necessary to win Food and Drug Administration approvals, has transformed 62 employees into millionaires. He has also created several baseball millionaires, since his 26 percent share of Marion has enabled him to buy 51 percent of the Kansas City Royals (his estimated minimum worth: $160 million)
- David Shakarian, whose father was the first yogurt importer in the U.S., built the immensely profitable General Nutrition Corporation. GNC owns a chain of large health food stores, whose stock includes many products under the company's own label (Shakarian's estimated minimum worth: $530 million)
- Arthur Jones, inventor of the Nautilus machines, is another beneficiary of the recent obsession with nutrition and fitness (estimated minimum worth: $125 million)

These new centimillionaires have joined older health-rich on the Forbes 400 list. E. Claiborne Robins, Sr. is patriarch of the family which prospered from the A.H. Robins Company and now has assets whose minimum value is estimated at $235 million. (E. Claiborne Robins, Jr., current head of the company, took a relatively modest $378,000 salary in 1983.) Close behind comes the Richardson family of Richardson-Merrell (formerly Richardson-Vicks), with assets valued at over $220 million.

Even the most successful of the new rich have a long way to go to match the Searle family of Chicago, whose holdings are thought to be worth over $930 million. However with health care expenditures currently topping $1 billion a day and rising rapidly, it is reasonable to assume that the first health billionaire will soon appear.
The breath of scandal has suddenly hit the Occupational Safety and Health Administration—hard. After three and one half years of seeming invulnerability to criticism for pro-corporate bias, OSHA now finds itself charged with not one or two, but four malefactions, ranging through conflict of interest, old-fashioned favoritism, political coverup, and human experimentation.

Auchter Under Investigation
Potentially the most serious case involves a charge of conflict of interest against former OSHA director Thorne Auchter, now being examined by the Federal Bureau of Investigation. On March 30, 1984 Auchter resigned as head of OSHA to become President of B. B. Andersen Companies of Kansas City. Earlier he had dismissed a series of twelve OSHA violations against this same company, including ten serious and two willful violations, with fines totalling $12,600.

At the time, in 1981, Auchter and his assistants had taken an active personal role in the case, according to Vernon Strahm, former OSHA regional director in Kansas City. Strahm says he was questioned by the FBI on the matter. It is against the law for a federal employee to accept anything of value in return for performing federal duties.

Strahm remembers the case well, since he believes his handling of it cost him his job. When he was OSHA regional director two of his inspectors went to look at B. B. Andersen Construction Company under court warrant, since company officials had previously refused to let them in. Originally OSHA wasn't supposed to inspect the plant since it did not come under the agency guidelines of belonging to a high-hazard industry. Strahm was verbally reprimanded for his handling of the case by three top national OSHA officials, including Mark Cowan, then Auchter's deputy assistant.

Later he was given a poor job performance evaluation—he had previously received good ones—and resigned rather than accept demotion.

Andersen, like Auchter, had been an active fundraiser in Ronald Reagan's 1980 presidential election campaign. Both had headed companies which were members of national builders associations. Strahm suspects the two knew each other, and believes this explains the unusually strong reprimand he received from the top for conducting an unscheduled investigation.

Rotten to the Coors
Another OSHA regional administrator also charged that he was demoted for investigating an Administration favorite. Curtis Foster, formerly administrator of the Denver office, got a personal phone call from Thorne Auchter dressing him down for allowing OSHA inspections of two porcelain plants owned by Joseph Coors of Denver, the arch-conservative personal friend of, and fundraiser for, Ronald Reagan. Coors Beer is on labor's boycott list because of the company's notorious union-busting record.

The plants had earlier been removed from the top priority inspection list by Washington OSHA officials. According to Foster, Auchter was "quite vocal" when he called, and told him "you need a situation like this like you need a hole in the head." This was "an unusual response for a minor foul-up," the regional administrator commented.

Soon after the inspections, Foster was demoted. He also chose to resign. His story was reported recently at Congressional hearings held by Rep. Obey (D-WI).

Thorne Auchter's deputy, Mark Cowan, flew to Denver right after the inspections to meet personally with Coors and other company officials.

Despite this record, OSHA officials insist that Coor's did not receive "special treatment" from the Reagan Administration, and point to ten OSHA inspections of Coors facilities since 1981. Representative Obey introduced into the hearing record the results of one of these ten inspections:

A female worker was overcome by fumes while working in an enclosed space. Two other workers died while trying to rescue her. OSHA cited Coors for failure to test the air in the space and to provide approved respirators and proposed a penalty of $810.

"I won't comment," Obey said, "the record speaks for itself."

A 34 year old lawyer and former CIA employee, Cowan, resigned soon after Thorne Auchter did. His new job is chief executive officer of the Home Builders Association of Metropolitan Denver.

Shaggy Dog Story
Charges of a political coverup highlight another incident of alleged illicit contacts between OSHA and industry officials. During a Congressional investigation of alleged ex parte contacts between Dr. Leonard Vance, OSHA's Director of Health Standards, and officials of Union Carbide Corporation, Rep. George Miller (D-CA) subpoenaed Vance's personal meeting logs. At first Assistant Secretary Auchter declined to honor the subpoena, saying the logs were personal material, not official government records. Under pressure, he relented.

David Kotelchuck is a specialist in occupational safety and health and a member of the Health/PAC Board.
Human Experimentation in Virginia

The case involving the most immediate and perhaps most dangerous threat to workers’ lives has already received a good deal of politically embarrassing media coverage. The State of Virginia’s OSHA agency, with the support and encouragement of federal OSHA, gave Dan River textile company permission to expose its workers to cotton dust above legal state and federal limits and to conduct medical experiments on the exposed workers!

Under this ruling, Dan River would have been exempt for at least six months from provisions of the OSHA cotton dust standard requiring it to install dust control equipment in ten of its plants. This would have saved it an estimated $7.5 million in equipment installation costs. Permission for the “test” was granted under a rarely used provision in the OSHA law which allows exemptions from standards to permit experiments designed to “safeguard the health and safety of workers.”

State and national labor leaders protested the OSHA move. “The Dan River firm has consistently held that brown lung doesn’t exist,” noted Virginia Diamond, a Virginia labor official. “Now they have decided to study something they say doesn’t exist. It’s clear to us it’s just a ploy to avoid installing engineering controls.”

The study, according to the company, was designed to test the theory that certain kinds of bacteria which grow on cotton cause brown lung disease, not the cotton dust itself. Brown lung is a disabling disease affecting tens of thousands of cotton textile workers.

To test this theory, the company proposed to let workers in its plants continue to breathe the same levels of cotton dust as they have in the past, often above the legal limit. Then medical scientists chosen by the company would lower bacteria levels in the workplace air to see if the bacteria, not the dust levels, are the problem.

The company and OSHA were quick to say that participation in the study would be “voluntary”; Dan River would pay each of the 200 workers who signed up $25. However any of them who contracted brown lung as a result would not get any worker compensation benefits, since Virginia is one of a number of states which do not cover this disease.

Critics also pointed out that those who do not “volunteer” would participate in the “experiment” anyway, since they would also be breathing in cotton dust at levels above those now permitted anywhere in the U.S.

Federal OSHA became involved in this questionable affair when Dan River asked it for funding at the same time the company applied to the Virginia state OSHA for the cotton dust waiver. Then-Director Auchter responded that his agency did not have money to fund the study; he suggested that it would be more appropriate to seek financing from the National Institute for Occupational Safety and Health (NIOSH), which conducts research for the federal government. In addition, he sent a strong letter of support for the proposal to Virginia OSHA officials, urging them to approve and assist the Dan River effort.

The OSHA scientific review process for the proposal consisted of Auchter’s director of health standards, Dr. Leonard Vance (see above), showing it briefly to two persons. The first, OSHA toxicologist Susan Harwood, looked at it “for an hour or two,” she said later. She wrote a memo calling the study poorly thought out and lacking in “scientific objectivity.”

“I am concerned about approval for human experimentation,” she warned, “This should not be used as a vehicle for escaping the compliance deadlines for the cotton dust standards.”

The other reviewer, Dr. Hans Welli, a lung specialist and an academic associate of the asbestos and textile industries, approved the proposal. However he now insists that he didn’t know the proposal involved exceeding legal dust level limits. “Very candidly, I don’t think it’s ethical to conduct research under conditions officially rated unsafe for human exposure,” he said in a recent interview.

Dr. Leonard Vance, who handled the federal review process for the Dan River proposal and drafted the letter which Thorne Auchter sent to OSHA officials, was formerly Assistant Attorney General for the State of Virginia. His boss, then State Attorney General J. Marshall Coleman, wrote him a letter of recommendation for his OSHA job. Coleman is now the lawyer representing Dan River in this OSHA case.

In early July Dan River decided to abandon the experiment, even though it had won OSHA approval. In announcing this decision, State Labor Commissioner Eva S. Tiegs said company officials were “very upset” that news reports on the controversy were damaging Dan River’s public image.

The Real Problem

Republican politicians are nervous and Democrats are elated by these recent revelations. Scandals and official corruption influence votes and help the party out of office. But the truth is, when it comes to scandal, history shows that it’s a no win game for the public—throwing out one set of Republican rascals just brings a similar set of Democrats in.

The real scandal of this Administration is its program of open class warfare. It has presided over the most massive transfer of wealth from poor and working people to the wealthy and big corporations in over half a century, lowering the living standards of tens of millions of American families in the process. OSHA’s scandals are just a small part of its frontal attack on the U.S. labor movement, from the brutal handling of the PATCO air traffic controllers strike to thousands of government rulings, regulations, budget allocations, and subtle and not so subtle public statements. Most of this is legal, but it would be hard to call it justice.
Sometimes the health care cutbacks of recent years have swept away entire programs, leaving an obvious wake of devastation. More commonly, however, the reductions erode; the effects may or may not be visible, may be immediate or may become evident only over time.

CATCH, Comprehensive Approach to Community Health, falls in the latter group. It was established in 1967 at the Jewish Hospital and Medical Center under a federal grant, a small beachhead in the War on Poverty. Designed on the maternal and child care model popular at the time, it offered its Crown Heights-Bedford-Stuyvesant community a full range of free services—health assessment, lab tests, standard immunizations, full dental services.

Until the 1982-83 budget cuts there was a comprehensive mental health staff of six. That is now entirely gone. Some of the patients were referred to the mental health center at the hospital (now merged with St. John's and called the Interfaith Medical Center) for followup care.

An Adult Service with an internist and a nurse team was established in 1971-72. That too has been eliminated. Other programs have lost staff, increasing the strain on those who remain and reducing services. My own experience has been in the ancillary services, where the cuts have been less noticeable from the outside, but crippling.

Originally the clinic had a community organizer position; before my arrival the designation had been changed to family health worker. When I first joined the staff outreach was not a problem: the program sold itself. We did have a small pamphlet and a one page flyer describing the program, but most of our new patients came through word of mouth. Our promises that “In CATCH you have your own doctor,” and “You can get everything done in one clinic” were powerful draws in combination with our reputation for courtesy and efficiency.

The primary outreach task has been ensuring that patients returned for important medical/dental and supportive followup. Often this has involved finding out why the patient missed an appointment. It has meant acting as the patients’ ombuds-person, their voice at the clinic. Many times it has required detective work: the clinic has always had a policy of continuing care even if a family moves outside our catchment area, and often I have had to locate patients through schools, welfare centers, building supers, and former neighbors.

Since many of our families have no phones and limited mail service, home visits have often been the only way, and are certainly the best way, of establishing a relationship with many patients who have not come in on schedule. In the early years these visits took up a major portion of my time.

All this changed with the budget cuts. Fees were instituted in response to government guidelines, and the clinic began to develop a “pay or die” reputation. As the staff was cut my clerical assistant was reassigned; the routine daily work of reviewing charts and sending broken appointment letters ceased. When the staff was cut further I became the registrar. Reminder notices were no longer sent out, even though checkups are often scheduled six months or more in advance.

Perhaps worst of all, there was no time for home visits. This shattered a crucial link with our patients. On these visits parents had often explained that the clinic appointments their children had been given were inconvenient or conflicted with an appointment at another agency. Sometimes they complained about aspects of the program or “attitudes” of certain doctors, nurses, or other staff members.

Obviously it's the families that require that little extra encouragement and concern from an “establishment” health care center that lose out. And the center loses them, to a Medicaid mill or some other service that may not offer the comprehensive care our program provides. Without this kind of outreach the center also loses a built-in critical resource. Who can better evaluate the effectiveness of our programs than the families who use them?

Home visits are also vital in detecting the social origins of disease. In the past year we have rearranged our staff assignments so that I once again have time for some, though not nearly so many as before. In one recent case, a doctor at the clinic asked me to check on a young child who had been coming in frequently this winter for colds and fever. When I got to his apartment it was freezing—there was no heat, no hot water, and a living room window had a hole in it. In another case, the doctor had noted a high lead level. I found the apartment clean but barren. It obviously hadn't been painted for

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by Georganne Chapin

Howard Waitzkin, physician, sociologist, and concerned human being, has synthesized the diverse perspectives of his life into an analysis of health and medicine in the United States. While not a history, his book uses a historical materialist approach to effectively hammer home the thesis that the American health care system can only be understood in relation to the nation’s political and economic system; problems within the health system emerge from and reinforce larger contradictions in society; and incremental reforms will have little impact in the absence of basic change in the social order.

The author took his title from a passage by Norman Bethune, a Canadian surgeon who served the Chinese Communist liberation forces. Commenting on the two diseases he had contracted, Bethune contrasted tuberculosis, whose cause and cure were known and specific, to the “second sickness” which he “caught from no one and from everything...I got it as a boy, as a man, as a doctor. It was much worse than tuberculosis...And many of the things I saw as a doctor only made it worse.” Bethune goes on to state that the turning point in his affliction with this second sickness came only after he “came to understand that tuberculosis was not merely a disease of the body but a social crime.”

Waitzkin’s goal is to describe, in a systematic and readable fashion, the “social crimes” that account for the special configurations of health, illness, and medical care in our society.

Part One, “Medicine, Social Structure, and Social Pathology,” the most theoretical section of the book, is an attempt to explain health care and illness in the United States in terms of our current social structure. Chapter One sketches a number of contradictions which interfere with health and, indeed, perpetuate illness among large sectors of the population.

One of these is the frequent contradiction between profit and safety. Waitzkin offers three examples, liver cancer among plastics workers; lung disease

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among asbestos workers; and “farm-worker’s back,” the debilitating arthritic condition common among migrant laborers forced to till the fields with a short hoe—a tool whose sole advantage is that it allows a foreman to tell by the laborer’s posture whether he or she is working or not.

Another contradiction he explores is that between plentiful resources and the maldistribution of health workers (especially physicians) and facilities. Here again, a number of examples emphasize the potentially tragic consequences of inadequate access to even the most basic health services. Waitzkin reminds us that social values which promulgate these inequities, such as the freedom of physicians to choose where they will practice, are class-linked; he then goes on to present characteristics of a system in which the poor would be “free” to obtain care.

Rising health care costs and diminishing returns, according to traditional health status indicators, comprise a third area of contradiction. Waitzkin presents a number of well-known facts—for example, that falling infectious disease rates preceded the discovery of antibiotics, and that poor people suffer from simple infections, poor nutrition, and infant mortality at higher rates than their wealthier counterparts. Although he notes medicine’s limited impact on the health status of large populations, Waitzkin eschews Ivan Illich’s medical nihilism, and stresses the need for basic, simple services such as prenatal care for poor mothers, noting (another contradiction) that even following such “mundane” practices might be “quite complex from the standpoint of the capitalist social system.”

Technological progress in medicine, he argues, is part of still another contradiction, since it teaches humanism from contemporary American health care. The effects extend from the emphasis of caregiving and emphasis on cure to alienation within the medical care setting itself, as health care workers are increasingly de-skilled.

Finally, Waitzkin makes a distinction between “reformist” and “nonreformist” reforms. Sounding a theme that will recur throughout the book, he cautions that under capitalism “the quest for progressive change...is often quite difficult because reform can slide into reformism. That is, improved material circumstances may seem beneficial but ultimately may reinforce the status quo by reducing the potential for social conflict.”

The question then becomes how we can address the inequities in health and in the distribution of services in such a way as to effect deep, lasting changes in the system which fostered these inequities.

The second chapter, “Social Structures of Medical Oppression,” is essentially a review of contemporary Marxist health scholarship, setting out themes elaborated in subsequent chapters.

These themes include:
- class structure—control over health institutions, stratification within these institutions, occupational mobility into professional positions
- monopoly capital—growth of medical centers, finance capital, the medical-industrial complex
- the state—its functions in legitimating the system and alleviating discontent, the private-public contradiction
- medical ideology—which views disease as a mechanistic, individual process and science as a vehicle for rational control of human beings, the expansion of medical management into many spheres of life, the excellence and esotericism of medical science.

Waitzkin then offers cross-national comparisons of health reforms, initiated under capitalist, imperialist, and socialist systems, as well as some recent findings on the health effects of economic cycles, stress, work/profit, racism and sexism.

Anyone who hasn’t made it through the original writings of the major historical materialist theorists in medicine will find the third chapter’s discussion of the contributions of Friedrich Engels, Rudolf Virchow, and Salvador Allende useful. For those of us who know of Allende principally for his tragically shortlived presidency in Chile, Waitzkin’s review of his earlier contributions to Marxist scholarship has particular value; they came within the context of imperialist expansionism and underdevelopment, and thus remain pertinent to current struggles for social and economic equality in the Third World.

Engels, Virchow, and Allende were quite distinct in their theoretical emphases; most critically, as Waitzkin points out, they differed over the still unresolved question of what the proper strategic balance should be between reformist and revolutionary alternatives.

In Part Two, entitled “Problems in Contemporary Health Care,” the author gets down to brass tacks with examples from medical technology, community medicine, and physician-patient interactions which remove any lingering doubts we might have about the presence of malignancies in the current system.

Chapter Four returns to contradictions previously outlined—those posed by technology, health care costs, and private profit. Waitzkin focuses on coronary intensive care units (CCU’s) as an example of health policy that makes sense only from the standpoint of profit under capitalism, since their proliferation is absolutely irrational from the standpoint of health and well-being. The generally held assumption that CCU’s reduce morbidity and mortality from heart attacks is not supported by any clear evidence. As Waitzkin shows, not one randomized controlled clinical trial on their effectiveness has been conducted. Widely cited estimates in the literature that CCU’s can prevent 45,000 deaths per year are based on the impressionistic data of one Kansas City cardiologist; his research was supported by a foundation whose board was saturated with bankers and corporate executives. Later studies in Great Britain and elsewhere indicate that victims of acute myocardial infarctions might be as well or better off in home settings as in a hospital CCU.

Rejecting the argument that high technology is blithely accepted in medical circles, Waitzkin points out that major actors in the development of CCU technology include several large corporations (among them Warner-Lambert and Hewlett-Packard), academic medical centers, private philanthropies, and the government itself; he argues that policy evaluation and decision-making based on cost-effectiveness and cost containment actually obscure the most fundamental motive in the expansion of health care technology—profit.

Chapter Five, “Social Medicine and the Community,” explores private medical expansion, the contraction of the public health care sector, and alternative systems—particularly community clinics. Focusing largely on urban areas, Waitzkin points out the cruel ironies of hospital expansion (coupled with other commercial urban renewal/efforts) into working- and lower-class neighborhoods. He notes that this growth of private medical facilities is
often subsidized by the public sector (through Medicare and Medicaid reimbursements, federal funds for hospital construction, and tax exemptions, etc.) but their services are often inaccessible to people in the surrounding or displaced community. The shrinking public sector is, in turn, increasingly less able to accommodate these patients.

In both the type of services they provide and their accessibility, community clinics, whose recent history goes back to the social turmoil of the 1960's, have provided sharp contrasts to large hospitals and private practice. Unfortunately, despite its 1983 publication date The Second Sickness is already outdated in its discussion of the numerous and chronic problems that clinics have faced as a result of their orientation toward social medicine and community services.

At this point the Reagan Administration's attacks and cutbacks are causing many of them to retreat from their practice of social medicine to the point where they provide little more than traditional public health services such as vaccinations and well-baby care. In short, community clinics suffer from the same problems as the social and economic system in which they operate. In addition, despite the difference they can make in individual lives and specific communities, community clinics do not achieve the goal of a unified health system.

Waitzkin argues that the principle political virtue of community clinics is their potential as a vehicle for community development and social change, often beginning with community-worker control of the clinics themselves.

The introduction to Chapter Six, "The Micropolitics of the Doctor-Patient Relationship," is an interesting, readable review of the issues of medical ideology and social control. Waitzkin is at his best integrating the ideas of Gramsci, Althusser, Habermas, and other Marxist scholars into a historical materialist perspective of medicine. After criticizing mainstream research on doctor-patient relationships as atheoretical and lacking historical and social content, he attempts to apply the Marxist theories to three encounters (presented in excruciatingly complete transcripts) between patients and their physicians.

These encounters, he argues, are examples of "The medicalization of social problems." The physicians represent, respectively, "medicine's social control over labor and the transmission of ideologic messages about work" (the patient is a middleaged man with heart trouble), reinforcement of "current relations of economic production" within the family (the patient here is a woman chronically disabled by mitral valve insufficiency), and heavy moralistic messages of self-control (given by the physician to a chronic smoker and alcoholic with terrible asthma).

The author's points are well-taken, and perhaps the detailed content analysis will be of interest to practitioners who deal in the physician-patient relationship persist under these systems; what occurs under capitalism in service to profit may be found in socialism in service to production.

The chapter concludes with an enumeration of several goals for a nonreformist relationship. First, the "domination, mystification, and distorted communication that result from asymmetrical technical knowledge" must be overcome on both sides. Second, a conscious attempt must be made to prevent medicine's symbolism from extending to nonmedical spheres. Finally, the social roots of personal suffering must be analyzed; physicians should provide technical intervention, but social supports must be available to care for the patient's social self. In short, the ideal relationship between doctors and their patients demands autonomy and longterm organized activism on the part of all concerned.

Waitzkin turns to ways that such goals might be attained in a section entitled "Policy, Practice, and Social Change." Using the examples of Chile and Cuba, he emphasizes the link between medicine and social structure.

In the pre-Allende years, health care in Chile was a three-tiered system. The upper classes patronized private physicians on a fee-for-service basis; the middle class relied on SERMENA, the national health insurance which also paid doctors fee-for-service; and lower-class Chileans, theoretically entitled to use the national public health service, were often deprived of care by underfunding and maldistribution of practitioners and facilities within the system. After he took office in 1970, Allende's program to make health services more equitable paralleled his approach to the reorganization of other sectors of society in the context of U.S. interference and Chile's heavy dependency on foreign currency: a slow—and, he hoped, non-alienating—route to change. Ironically, the strongest domestic opposition to the president-physician's policies came from his own peers in the powerful and highly organized private medical sector.

The swiftness and completeness of the Cuban revolution, on the other hand, enabled the new government to build a new health care system from scratch. Nonetheless, serious problems had to be confronted—particularly the mass exodus of private medical practitioners and severe shortages of currency to purchase...
pharmaceuticals and other medical supplies and little capacity to produce them. The total revamping of the social system, however, made the necessary structural changes in health care possible, from medical education (no longer class-biased) to more equitable distribution of services to community-based decision-making. The enormous advances in the health status of the Cuban population are one proof of their success.

The conclusion of Chapter Seven and the crux of Chapter Eight, "Health Praxis, Reform, and Political Struggle," return to the crucial issue of reform versus reformism, examining it in the context of the United States today. Many leftists are well-versed, in retrospect, in the errors committed—or, perhaps, limitations encountered—by the Allende government in its aborted movement toward socialism. Waitzkin bravely asks the key question, "If the attempt to achieve nonreformist reform and peaceful transition failed in Chile, what are the chances in advanced capitalist nations like the United States where political power, economic resources, and military strength of those opposed to structural change are even more extensive?"

He does not provide a definitive answer to this question in his final discussion of progressive health praxis. He does, however, offer a critique of some of the policies and strategies which have been proposed. Illich and other "new reductionists" are criticized as insensitive to class inequalities in illness and health care, as too narrowly focused on the role and responsibility of the individual, and therefore as legitimizers of current trends toward cutbacks in publicly funded health programs. National health insurance, health maintenance organizations, and group practice, and professional standards review organizations come under attack as "reformist reforms" that do not entail changing the overall structure of the health care system.

Like his discussion of community clinics, Waitzkin's material on current systems of finance is unfortunately already outdated. Changes underway, such as prospective reimbursement and the advent of diagnostic-related groups (DRG's) could affect the organization of care much more dramatically than previously utilized fee-for-service reimbursement systems have.

Waitzkin's forecast of the uncertain climate for a national health service, on the other hand, is relatively up to date, due to the lack of forward movement on that front. His position on it, however, is confusing. While he praises a system such as the one called for in the Dellums bill as a "nonreformist reform," he acknowledges that it is unlikely that any national health service can avoid falling into reformism under advanced capitalism. All the countries in which an NHS has succeeded have socialist economies, he notes, and the case of Great Britain demonstrates how an NHS within a capitalist society...can contain elements of reformist reform such as its effects in reducing the militancy of labor. The key to ensuring that an NHS becomes a true reform lies in its implementation as a "bottom up" phenomenon, he argues. The problem of achieving such goals in a class-stratified, capitalist society has long plagued the left.

The book concludes by outlining goals activists should raise in their work to achieve fundamental changes in the system. No one reading The Second Sickness is likely to argue against any of them: demystification of medicine; linkage of the alternative health movement to broader activism; bans on indiscriminate drug testing in the Third World and the excessive promotion of drugs and infant formula there; improved occupational safety and health; and so on. More generally, he tells us that we must oppose the "new" right, racism, and processes that threaten to degrade the physical environment beyond repair if we are to have a world worth working for at all. The heart of effecting change in any of these areas lies in hard work, commitment, and mass organization. And we now have the opportunity to take advantage of the crises that advanced capitalism generates.

Waitzkin is correct, and it's unfortunate that people who don't already agree with books like this mostly don't read them. The analysis is largely done; what we need now is the impetus and direction for the work.

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Georganne Chapin is a doctoral student in the Division of Sociomedical Sciences Program at Columbia University and employed at the ERIC Clearinghouse on Urban Education.
years; lead-based paint and plaster were peeling and falling all over.

In both these instances I talked to the mother (a large number of families in this community are headed by single black women, who are often under such pressures that they are particularly vulnerable to exploitation by slumlords and others). The visit enabled me to suggest ways of putting pressure on the landlords, such as withholding rent and initiating court action, to get repairs made. I was also able to make appropriate referrals to our program’s social service for immediate intervention, and to document what I had seen for the social worker as well as the doctor and nurse. I could reschedule the children’s appointments and follow up to see that they were kept, and that the needed assistance had been obtained. Most importantly, I was able to urge the parent to inform the doctor, the nurse, and the social service department about problems that are directly or indirectly health related, and to be persistent in exercising their rights as health consumers.

Without such visits, a clinic like ours was inevitably on a downward spiral. Patients could not be adequately treated when their environment was ignored. The number of missed appointments soared, and the clinic responded by overscheduling. Unscheduled “walk-in” visits increased. Waiting times grew longer, and more patients became discouraged and stopped coming or keeping appointments.

In retrospect, it is clear that the clinic’s assumption was that the families needed us and they would continue coming in spite of poor service or difficulties in keeping appointments. In fact, even from the business perspective increasingly adopted in response to the budget cuts, we needed them. Our jobs, indeed our type of health care over the “competition” offered by numerous local “Medicaid mills” and the hospital’s outpatient pediatric clinic one flight downstairs from us—a lifestyle of crisis oriented care congenial to many which gave a lot of business to the hospital emergency room.

The clinic is now attempting, within its severe budget constraints, to reverse this process. In conjunction with the reinstitution of home visits the staff gives regular attention to patient complaints. Families are routinely informed of the clinic’s policy of allowing them to switch doctor/nurse teams. A free care category has been re-established and the program is attempting to reduce or eliminate lab fees and pharmacy charges. Waiting time is still a problem, but TV’s have been installed in the outpatient department.

Even with these improvements, the CATCH program must still find solutions to its long term problems which will permit it to survive with its original goals at least somewhat met.
Open Doors

Sourcebook on Lesbian/Gay Health Care is the first national publication devoted to both the issue of access for its constituents and a listing of services available to them. Included are essays on gay and lesbian health problems, abstracts or presentations at the First International Lesbian/Gay Health Conference (held in New York this June), listings of appropriate care providers and organizations. Copies are $10. Checks should be made out to the National Gay Health Education Foundation or the Health Fund and sent to P.O. Box 784, New York, NY 10036.

Salud

Links, a new publication of the Central American Health Rights Network/East Coast, offers news and analysis you won't find in any other single source, if you find it elsewhere at all. An indispensable newsletter for any activist concerned with health rights in Central America. Subscriptions are $10 for individuals, $25 for institutions, and $40 for sustainer. Make checks payable to the Committee for Medical Aid to El Salvador—Links, and mail them to P.O. Box 407, Audubon Station, New York, NY 10032.

Great Speckled Phoenix

Contrary to widely-held belief, Atlanta's foremost underground institution is not its subway, but the Great Speckled Bird, alive once again after a lapse of several years. Anyone interested in Southern politics will want to send a $12 check made out to Atlanta Progressive Media Foundation and mail it to The Bird, P.O. Box 4532, Atlanta, GA 30302.

Films and Videotapes

Tell Them I'm a Mermaid is an entertaining musical-theatre presentation starring seven women with disabilities. They tell what it means and doesn't mean, and how they lead happy, productive lives. Shown on television in December 1983, and available on either 16 mm. film or on tape for rental of $100 a week. Write Embassy Telecommunications, 1901 Avenue of the Stars, Los Angeles, CA 90067; Attn. Andy Kaplan.

Caring for Aged Parents is a new documentary-style film which raises questions without trying to provide definitive answers. Rental is $45, purchase is $75, from Terra Nova Films, Inc., 17832 67th Ave., Tinley Park, IL 60477.

Paychecks and Promises: The Impacts of Economic Development provides a hard-hitting expose of how job creation can also mean disease creation, as well as anti-union, low-wage companies. Based on case studies in North Carolina, this 32-minute videotape shows all the dangers. Music by Sweet Honey in the Rock (anyone at our annual dinner can testify how wonderful they are). Available in 3/4" and 1/2" for non-profits and unions (rental $35, purchase $75) and other institutions ($50 rental, $125 purchase) from NCOSH, P.O. Box 2514, Durham, NC 27705.

Untimely Ripped

"Childbirth has been taken away from women," is the starting point for the Cesarean Prevention Movement's founder, Esther Booth Zorn. "It is incredible that there should be so much pain over something that should be so happy." The three year old CPM now has chapters in many parts of the country which hold forums, maintain lending libraries, conduct hospital surveys, and offer vaginal birth after cesarean (VBAC) classes. Its quarterly newsletter has a circulation of 4000. For more information, write Cesarean Prevention Movement, P.O. Box 152, University Station, Syracuse, NY 13210.

Imported Goods

Nicaraguan pure arabica coffee is now available in the New York area for $3 a bag ($5 a bag for supporters), $60 a case when payment is enclosed. Write to Adelaide Trading, Inc., P.O. Box 1563, New York, NY 10025.

Virtually everything else you'd want from Nicaragua, including records, handicrafts, films, videotapes, magazines, newspapers (including Barricada's English edition), and books, is available from the newly-opened New Society Products, 853 Broadway, Suite 105, New York, NY 10003. Tel. (212) 254-0853.
The Last Word On Sleep
by Arthur A. Levin

It is one thing to have self-inflicted sleep problems, but quite another when it is a bedmate's problem, and your sleep that suffers. The subject of many comedy skits, snoring can be a persistent, annoying problem to snorer and listeners, and in some cases can signify serious health problems. Sleep experts question how annoying it to others snoring really is, and point to the ease with which most of us adapt to the urban cacophony of grinding garbage trucks, screeching car brakes, shrill sirens, and piercing screams—or in the country, to crooning owls, barking dogs, chirping crickets and croaking basso bull frogs—as support for their argument that it is those who already have their own sleep problems that are most affected by someone else's snorts and grunts.

Most snoring is intermittent and without medical significance, but for those who snore all night, most nights, it can indicate a shortage of oxygen that may lead to fatigue, or even cardiovascular or neurological problems. Less often, chronic snoring may mean the person is suffering sleep apnea—a potentially fatal problem where the person actually stops breathing for a short time and then resumes breathing for a short time.

Sleep apnea can result in high blood pressure, arrhythmias (abnormal heart rhythms), and heart strains. Nine out of ten people with sleep apnea are male, and most are obese. It can be corrected by weight loss or a variety of medical and surgical interventions, ranging from antidepressant drugs to a tracheotomy (a surgically formed breathing hole in the windpipe). The latter is performed to prevent the complication, inevitably fatal, of not breathing for a long period of time.

Some experts who have studied snoring believe that it may occur when nasal passages are blocked, since most of us breathe through our nose when asleep. Their suggested remedies include use of mainstream medicines such as sprays and decongestant drugs. Physical problems such as a deviated septum may require surgical correction. Before rushing to drugs and surgery, however, it's worth trying to make sure you sleep on your side (the position least conducive to snoring) or propped up by pillows, stop smoking, and avoid substantial food and alcohol intake in the evening.

Strange as it may seem, recent evidence collected on persons attending sleep disorder clinics indicates that the majority suffer from hypersomnia, which is excessive daytime sleepiness, rather than insomnia. While some may ridicule the person suffering hypersomnia, their problem is not a joke and may put their careers, relationships, and lives in jeopardy.

The most familiar kind of hypersomnia is narcolepsy—falling off into "mini-sleeps" many times during the day. These so-called sleep attacks can occur during any activity—while eating, driving a car, or even during sex. A typical narcoleptic will have 15 to 20 sleep attacks, each lasting anywhere from a second to 15 minutes during a given day. While exact numbers are not known, it is estimated that there are at least several hundred thousand people in the U.S. with this condition—although many who have it are not properly diagnosed and do not know it.

People who specialize in the care and treatment of narcoleptics point out that many exhibit what is termed excessive daily sleepiness (EDS) or hypersomnia. They emphasize the EDS as well as sleep attacks should be considered as symptoms of possible narcolepsy. Narcoleptics also often exhibit "cataplexy" which is a rapidly occurring loss of voluntary muscle tone (usually occurring during periods of strong emotions). At worst, cataplexy can result in an inability to move or speak.

Narcolepsy usually begins between the ages of ten and 30; it is rarely seen in people over 40 without a previous history. When it occurs in young children it can be misunderstood and misdiagnosed, leading to an extremely difficult and traumatic life until proper diagnosis and care is provided.

Unfortunately, little is understood about the cause of narcolepsy, and treatment is limited to alleviating symptoms with long term chemotherapy—stimulants such as Ritalin and Dexedrine to deal with EDS, and the tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) to treat cataplexy. One booklet published by the American Narcolepsy Association contains this statement:

The challenge for both physician and patient is to find the lowest possible dose which is not merely adequate to maintain marginal functioning, but which is truly effective: the medication and dosage which allow the patient a real improvement in the quality of their life.

Fortunately, the vast majority of those who complain of insomnia have a much milder problem which, though many don't believe it, is usually easily remedied with non-invasive alternatives to medical treatment. Current research indicates that the key factor is relaxation, which can be accomplished by the following:

• Vigorous exercise. One of the side benefits of the fitness boom is that many participants claim they sleep better and are able to relax more easily.
• Specific routines such as progressive relaxation technique, e.g. concentrating on one part of the body at a time.
• Self-hypnosis.
• Biofeedback used in combination with a program such as progressive relaxation.

The Last Word On Sleep by Arthur A. Levin
• Avoiding use of the bedroom for extra-mattress stimulation, e.g. late TV, studying, arguments. The room should be associated with good sleep, sex, and no other activities.

• If unable to sleep, get out of bed and engage in some activity in another room. Do not get back into bed unless sleepy.

Arthur A. Levin is Director of the Center for Medical Consumers, publisher of Healthfacts, and a member of the Health/PAC Board.