Government Cost Control Strategies:

FUTILE MONITORS. Escalating costs rooted in high-technology care create a crisis in health policy.

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SUPPOSE THEY GAVE A PROFESSION AND NOBODY CAME. A backwater of medicine at the frontlines of care has few takers.

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Vital Signs

Government Cost Control Strategies

Campaign promises of national health insurance were barely off Jimmy Carter's lips when the new Administration found itself ambushed by a crisis that has been brewing for at least a decade—that of skyrocketing health care costs.
The crisis into which the new Administration stumbled is complex, extending beyond costs to the effectiveness of health care itself. Its unprecedented proportions—health costs rising at 10 percent a year, outpacing every other component in the Consumer Price Index—promise to reshape not only the health care system, but quite possibly Americans' concepts of disease, medicine and health as well.

Between 1970 and 1975 total US health expenditures doubled; by 1980 they will double again, predicts the Congressional Budget Office. This means that from 1970 to 1980, costs will have jumped from 7.1 percent of the GNP to an astounding 12.3 percent. Perhaps most alarming to government officials is the 813 percent jump in federal health spending over the last ten years. "We have no more urgent, immediate priority than to deal with runaway health costs," declared newly-appointed HEW Secretary Joseph Califano in late February, announcing that national health insurance would take a back seat to cost control, at least for this year. (See Washington column, this issue).

But lurking behind the crisis of cost and exacerbating its effects is a second, still largely incipient crisis in health care—a crisis of public confidence in the efficacy of the delivery system and in modern medicine.

Despite massive expenditures, life expectancy in the US has remained essentially unchanged for the last quarter century. The US continues to trail 16 industrialized countries in infant mortality rates. Recent "wars" on heart disease, cancer and stroke notwithstanding, these epidemics burgeon unabated. John Knowles, president of the Rockefeller Foundation, captures the popular mood:

"There exists a profound national concern that despite a massive increase in health expenditures over the past decade, the nation's health has improved less than was promised or expected. The benefits have not appeared to justify the costs." (4)

Crisis: Midwife to Change

Such rapid cost increases combined with diminishing returns in health care results would seem to constitute a crisis even in ordinary times. With the nation weathering a severe recession, however, they become utterly intolerable. Added pressures from within the federal government for fiscal austerity combine with external pressures from increasingly unhappy employers, labor unions and a general public to suddenly force the issue of cost control. And some fundamental changes within the system are beginning to result:

- Under the strain, the post-World War II public-private alliance in health care is cracking. Born in the 1940s with the first major infusions of federal research and Hill-Burton construction funds into the health sector, this cozy alliance has grown until today the federal government pays 32.7 percent of all health care expenditures. Together federal, state and local government pay 42.2 percent. (5)

Indeed, it was this increasingly generous public subsidy, combined with the equally generous, open-ended contribution of Blue Cross, that fueled not only the growth and dominance of medical empires, but underwrote development of the high-technology, highly-specialized, institutionally-based model of clinical medicine they promoted and that prevails today.

Yet the very subsidies that stimulated the rise of the empires' power also sowed the seeds of their eventual demise. Irreversibly dependent on public support, the managers of these bloated institutions could not even imagine conducting research, training personnel, building or operating facilities, or virtually any major activity within their walls, without massive public subsidies.

Meanwhile, both financially and politically, government officials can no longer afford to remain servile to the private sector's interests. Thus, for the first time in decades, the private sector—not only facing unprece-
dent dependence but suffering its own fiscal crisis as well—is no longer in a position to call all the shots.

- In its place, the public sector is emerging as the dominant force in the health system. Responding to the growing thunder for cost control, public officials have for all appearances accepted Health/PAC's “profits, prestige and politics” analysis of the private sector, and have begun to incorporate it into policy. The powerful Council on Wage and Price Stability fingers open-ended, cost-based Blue Cross, Medicare and Medicaid funding to hospitals (6) while Paul J. Feldstein, health care economist at the University of Michigan, posits the “prestige hospitals hypothesis” of rising costs. (7) The health system seems to have been desanctified, with government officials setting out to tame the “medical empires” and the “medical industrial complex.”

Regulation

The main weapon in the government cost control arsenal has traditionally been regulation. Thus, the 1970’s have seen regulatory measures replace spending programs as the dominant theme of federal health legislation. Such regulatory programs as Professional Standards Review Organizations (PSROs) and Health Systems Agencies (HSAs), while hardly models of effectiveness, have become important precedents. Never before have representatives of the federal government reviewed the appropriateness of medical decisions (as in PSROs), sat in judgment of private expansion decisions (as in HSAs), forced doctors to write generic prescriptions (as in the Maximum Allowable Cost program), told medical schools what specialties to emphasize and who to admit (as in the new health manpower act) or openly peddled a particular form of medical practice (as in Health Maintenance Organizations). The Federal Trade Commission in the last year has unleashed a full scale attack against antitrust activities by hospitals, physicians and other provider groups. And, in the

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services, providers tout their every "miracle cure," and an anxious public increasingly buys into the seductive ideology of its scientific/academic/medical establishment: that all things are possible through science and technology, given enough resources. No significant attack on either the cost or effectiveness of care can succeed if it leaves this notion unchallenged.

Cutbacks

One alternative to the regulatory approach, of course, has been the "New York Solution"—swift, simple, across-the-board slashes of the budget cutter’s axe that let the bodies fall where they may. (See BULLETIN, March/April, 1976). The problem with this tack, aside from eventual political constraints, is that it runs aground on the same shoals as regulation: The contradictions of the acute, hospital-based clinical model of medicine render its successes short-term at best and counterproductive at worst.

Given the current model of care and the power configuration that promotes it, cutbacks invariably take the least rational course both financially and in terms of health needs. They strike first and most fiercely at ambulatory and preventive care—neighborhood health centers, prenatal care, well-baby care, immunization programs, school health, food stamp, school lunch and other nutrition
programs, venereal disease, family planning and home care programs—which, while inexpensive, are considered marginal, medically and politically, compared to the funding of high-technology hospital services.

The consequence is more and sicker patients who increasingly have no recourse other than to hospital emergency rooms and the outpatient departments where costs range from $20 to $75 a walk through the door. The impact of budget cutbacks has been to consolidate resources around the most expensive and dubiously appropriate model of care—a development that in the long run exacerbates the very crisis it is meant to assuage.

**Beyond Cost:**

*The Limits of Modern Medicine*

Without radically departing from the currently-accepted model of care, there can be no significant attack on costs. Ironically, then, the cost issue alone ultimately forces reformers to go beyond quantitative issues to deal with the very nature of care delivered, its quality and its effectiveness.

Accelerated by a new age of scarcity, America today confronts nothing less than the limits of its commodified medical science, of the easy-fix, moonshot mentality toward health and every human problem. With no easy vaccine for cancer, no pills for heart attacks, no machines to deliver a vulnerable populace from the perils of an industrialized environment, the disjuncture between cost and efficacy grows ever sharper. As the contradiction deepens, the very system itself will be forced inexorably toward a new mode of delivery that must be, by contrast, much more strongly reliant on decentralized, inexpensive primary and preventive services.

For those whose concern extends beyond the predicaments of public policy makers and budgeteers, this development offers both progressive and regressive potentials. A new emphasis on primary care holds the possibility of less costly, more accessible and more appropriate health services on the one hand. On the other, it offers the possibility of a more thoroughly rationalized and dualized system providing the best of technologized medicine for the few and third-rate, paramedic-delivered, free-standing clinic care for the many. Likewise, preventive care—with its focus on the causes of disease—in progressive hands will point toward social, economic and environmental conditions. In regressive hands, however, preventive care can offer a rubric under which government and providers together shrug off active responsibility for health problems—placing the onus for illness and responsibility for solutions on the shoulders of the individual.

Significant changes in the present health system suggest a new struggle to dramatically change public expectations. The beginning of an ideological campaign—one that contains, to date, a mixture of progressive and regressive elements—is already in evidence. Its general purpose appears to be the reduction of public expectations of modern medical science, the health system and the government, thereby reducing demand for health care services and reducing costs as well. It derives significant momentum from growing public disenchantment with rising costs and diminishing returns of modern medicine. It teaches the importance of personal self-sufficiency and self-help on the one hand; it blames victims for their condition on the other. Its ideological support ranges from the works of a Victor Fuchs, who argues the economistic limitations of modern medicine, (8) to an Ivan Illich, who not only...
doubts the effectiveness of modern medicine but believes it physically, psychologically and socially harmful as well. (9)

**Implications**

Public policy makers will eventually be forced to wrestle with the crisis of care as they struggle toward coping with the crisis of costs. But these same crises can offer strategic opportunities for health activists as well. The collision of the issues of cost, access and distribution of services with those of quality, content and effectiveness of care vaults over the defensive, dead-ended, “fight-the-cutbacks” strategy adopted by so many groups with so little success in an era of economic contraction. By stressing again that the issue is seldom money itself, but how it is spent and what it buys, a new health perspective can enable today’s activists to avoid the liberal temptation, when faced with the budget cutter’s axe, to drop a critical stance and defend an otherwise-utterly indefensible status quo.

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The joining of the issues of quality and content, appropriateness and effectiveness provides the most hopeful potential for that political unity and support long lacking among so many workers and communities hit worst by the budget cutbacks and slashed services.

A new analysis also offers a meeting ground for two crucial but heretofore separate and (often) antagonistic camps: those such as the poor, oppressed, and minorities whose rallying cry has been equity in access and distribution of services, and the large, often amorphous group who sense that something about modern medicine is fundamentally wrong—those attracted to the arguments of the women’s health movement, the self-help movement and Ivan Illich, for example. To the latter, a new analysis offers new political expression for what has until now been a diffuse and personal discontent.

Finally, the above analysis raises important unanswered questions that health activists will be forced to address in coming years. What implications will the decline of the private sector and the rise of the public sector have for the target and strategy of radical struggles? How will radicals distinguish themselves, in ideology and in struggle, from the ever-more-dominant forces of rationalization and reform? How can they use, and not be used by, these forces? It is clear that such prospects suggest a complex situation, a struggle engaging both the progressive and the reactionary, which will require a more complex response than has been necessary in the past.

—Ronda Kotelchuck

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Training Occupational Physicians

The National Institute of Occupational Safety and Health (NIOSH) estimated in 1972 that the US faced dramatic shortages of occupational health personnel. Among the most striking needs cited was that for an immediate increase of 3,000 occupational physicians. (1)

Yet, despite the growing demand for such physicians and increased national attention to occupational health and safety since passage of the federal Occupational Safety and Health Act in 1970, the occupational physician in America might aptly be characterized as an endangered species.

Less than four of the roughly 10,000 medical students graduated in the United States each year go on to specialize in occupational medicine—an 80 percent decline in the past six years. (2) Of those who do elect such training, nearly one-third change their minds by the end of the first year. (3) Thus, three-quarters of the annual available residencies in occupational medicine go unfilled. (2)

The number of physicians actually working in occupational medicine has been variously estimated at 4,000 to 10,000, depending on how occupational medicine practice is defined. (4) Most of these are private physicians who provide companies with part-time or on-call services. The great majority are older men without special training in the field; a mere 450 are board certified.

Three factors help explain the bleak condition of the field of occupational medicine: (1) the inadequacy of US medical school and public health training programs; (2) the orientation of residency programs toward industry needs; and, (3) the conservative social and scientific attitudes of the American occupational health establishment.

Medical and Public Health Education

The screening of medical school applicants eliminates from the beginning those most familiar with and potentially most interested in occupational health problems. A crucial determinant is family income—the ability of a student’s family to pay the estimated $10,000 to $50,000 for four post-college years...
of study. The median family income of the 1975 entering class was $21,333—far above the median US family income.(5) With medical school scholarships virtually non-existent, medical training is clearly out of the question for all but a handful of working-class students.

Once in medical school, students are trained to be clinicians, to think in terms of medical treatment on a patient-by-patient, fee-for-service basis. The high cost of medical education encourages doctors to charge large fees once in practice and to believe that such fees are both justified and deserved. Once the average American physician begins to practice medicine, he or she has been tailored by education as well as by class background to fit the most traditional concept of medical practice.

Medical training itself contains virtually nothing about job-related diseases, reflecting the field’s low esteem within the medical profession. Currently, only 12 of the more than 100 US medical schools include occupational health in their curricula.

Treatment of occupational health in medical education is typified by the experience of one current student in her last year at Johns Hopkins School of Medicine. During her entire medical education, the only concrete reference to an occupational disease this student could report was a brief mention of black lung disease in the course of a “fifteen-minute discussion of environmental exposures.” Course after course neglected the link between occupation and disease. Job-related pulmonary diseases went unmentioned, as did occupational etiology in discussions of cancer. A course in dermatology provided a one-day lecture on rashes without discussing occupational causes and without noting dermatitis as a leading occupational disease. Instruction on hearing loss never included analysis of occupational exposure to noise as a major cause.

Faithful to their training, American physicians routinely ask a patient’s job when taking a medical history. That same training, however, leaves them unequipped to utilize this vital information.

Special training in occupational health is available to medical students as well as those who have finished medical school at a number of schools of public health that offer occupational health courses. Such schools usually grant master’s degrees in public health. Very few medical schools, however, integrate such training into their own curricula; training usually must be obtained before or after internship and residency.

Only five of the 19 accredited US public health schools offered programs in occupational health in 1975-76, and the total enrollment in these programs was miniscule: Harvard, one; Illinois, seven; Michigan, 12; Pittsburgh, 31; and Texas, two.(6) (However, some schools of public health offer occupational health instruction as part of other programs such as environmental health or environmental medicine.)

Residency Programs in Occupational Health

Approved occupational medicine residency programs take three years. The resident’s first two years are spent in one of five academic programs approved by the AMA’s Council on Medical Education and the American Board of Preventive Medicine. These five programs, and the number of positions they offered in 1975-76, included: Harvard University School of Public Health (four, each year); University of Rochester School of Medicine and Dentistry (two, first year); University of Cincinnati Department of Environmental Health (eight, each year); the University of Oklahoma Department of Environmental Health (two, each year); and New York’s Mt. Sinai School of Medicine (three to four, each year).(7)

Of the 20 approved third-year programs, only two are academic. These two programs, and the number of positions open in 1975-76, included: Harvard University Health Services, Division of Environmental Health and Safety (one), and Mt. Sinai School of Medicine (three to four). The Mt. Sinai program is an integrated three-year program, offering practical training at Mt. Sinai Medical Center and with union groups.

Seven governmental agencies and eleven industries also offer approved third-year
Occupational medicine residencies generally require external funding that is both undependable and quite low by contrast.

residencies. These programs and their 1975-76 openings included: National Aeronautics and Space Administration (one), United States Air Force (one), United States Army (four), Atomic Energy Commission (one), US Navy (four), US National Institute for Occupational Safety & Health (one), Tennessee Valley Authority (one), Kaiser Steel (one), E.I. duPont de Nemours (one), Ford Motor Company (none), General Motors (two), Dow Chemical (one), American Telephone and Telegraph (one), Eastman Kodak (two), Jones and Laughlin Steel (none), Hanford Environmental Health Foundation (one), Boeing Company (two), and Allis-Chalmers (one).(7)

Salary levels probably present no obstacle to medical students in choosing occupational medicine as a career. A young occupational physician might earn around $35,000 a year and later, as company medical director, much more.

For the resident, however, occupational medicine presents a distinct disadvantage in terms of income. Residency funding in other specialties is generally based on ability to provide essential patient care services and is largely paid by the teaching hospitals themselves. These stipends range from $11,000 to $15,000 per year. Occupational medicine residencies, however, generally require external funding that is both undependable and quite low by contrast.

During their third year, residents in occupational medicine commonly receive clinical training with a company while on salary, which orients them toward industry even before their careers have begun. This orientation has been reinforced during the past six years as the number of academic residency programs in occupational medicine has declined by nearly 50 percent while the number of in-plant programs increased by more than 30 percent.(8)

Government stipends for residents in occupational medicine would not only increase the number of students selecting the field, but would also eliminate this "buying" of third-year trainees by industries. This should be a major priority for NIOSH in the near future, but given its chronic underfunding the situation does not look hopeful.

Of NIOSH's total budget of $41.6 million for fiscal 1976, only $3 million went for training grants. Of this $3 million, $424,021, or only 14 percent of the training grant budget, was awarded to four medical schools to develop residency training programs: University of Cincinnati ($148,362), Mount Sinai ($106,760), Harvard ($82,663), and University of California at Irvine ($86,236).

(9) There were no grants for training during the first four years of medical school. According to one NIOSH official, medical schools are "not interested" in expanding their curricula to include occupational medicine, and the general feeling within government is that subsidizing medical education constitutes poor use of public funds since physicians have such high incomes.

The Health Professions Educational Assistance Act passed in October, 1976, on the other hand, should provide a giant step in the right direction if funded adequately. The Act provides, among other things, for the creation of 10 regional occupational health training and education centers connected with existing medical and public health schools.

These centers would establish new graduate occupational health programs. Thus, for the first time, federal funds will provide residency training in occupational health and continuing education for already practicing occupational physicians. Each center would train 10 occupational physicians per year.

The Act also provides special project grants for existing public health schools and graduate programs in health administration. These grants are earmarked for development and expansion of specialty programs, including environmental and occupational health, and provide for residency stipends at levels competitive with other specialties.

Many medical students attracted to occupational health during the 1970s would
prefer not to work for industry. For them, a major deterrent to occupational medicine as a career is the lack of alternative positions once they finish training. Such alternatives continue to be scarce. NIOSH now employs

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"Have you ever tried to change a medical school curriculum? It's an empire; you can't change it."

Dr. Harry Howe
former Secretary, AMA's Council on Occupational Health
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32 occupational health physicians and has openings for eight more this year. Labor organizations, historically concerned with "bread and butter" issues, employ few occupational physicians. A recent survey of 15 national unions representing over seven million workers revealed only 22 full-time occupational health staff, of whom only one is a physician. Although the situation is changing, change is slow and labor will not be ready to support occupational physicians in large numbers in the near future.

The Occupational Health Establishment

Over and above the medical profession's general lack of interest in occupational medicine, an important reason for lack of wider student interest is the attitude of recognized leaders in the field of occupational health.

Dr. Henry Howe, former secretary of the AMA's Council on Occupational Health, cites a major function of the Council as recruiting. Dr. Howe notes that there are some 60 Council publications that provide information for company physicians and seek to improve management-physician relations. But the Council publishes virtually nothing geared to stimulating the interest of medical students because, in Howe's words, "It wouldn't do any good; they don't teach occupational medicine in medical school." Asked about the possibility of making changes in these curricula, Howe responds, "Have you ever tried to change a medical school curriculum? It's an empire; you can't change it." The way to attract more people to occupational medicine, Howe believes, is "By offering jobs with good salaries. The shortage is produced by the taxpayers who don't want to pay for it."

Although such buck-passing by the AMA comes as no surprise, one would expect greater concern from a group such as the American Board of Preventive Medicine. One of its principal purposes, according to its Certificate of Incorporation, is "to encourage the study, improve the practice, elevate the standards, and advance the cause of preventive medicine."

However, Dr. John Hume, Chairman of the Board until 1974 and Dean of the Johns Hopkins School of Hygiene and Public Health, when questioned about the need for preventive and occupational specialists, told this writer in 1972: "What we need are more people in the other specialties. If I were sick, I wouldn't go to someone who specialized in occupational or preventive medicine, I'd go to a specialist in the applicable field." What about workers' needs for trained occupational physicians? "Workers really have no problem," Hume said, "because if they have health problems they can always go to their company doctor."

When lecturing or writing prominent occupational physicians often reinforce an image of fuzzy thinking and questionable motives. Dr. Irving Tabershaw, editor of the Journal of Occupational Medicine, for example, noted in a 1971 lecture entitled "Occupational Medicine: The Search for Identity,"

"Health care delivery systems for the employed should be determined by industry which provides the wherewithal (the money) and the consumer, i.e., the working man (and his dependents), who determine the use of these services. If the physician, the provider of the services, is responsive to both forces, the scope of medical practice will reflect the interplay between the two. But industry, the producer, has abdicated its role of compromising and modifying the demands of labor for health care. And labor, the

(Continued on p. 19)
THE 9% SOLUTION

Washington, D.C., March 1. A thousand hours have ticked by. President Carter's health braintrust—young, technically idealistic, and Southern accented—has a year's end deadline for their National Health Plan. The new team's mandate appears two-fold:

• Contain the medical—particularly hospital—cost explosion. Notable is the announcement from Carter and his HEW Secretary, Joseph Califano, Jr., that the government will soon act to limit annual hospital cost increases to nine percent.

• Avoid negative impacts, however veiled, on the nation's "vulnerable citizens"—Califano's term for children, the poor, the handicapped, the elderly, and "disadvantaged minorities."

Preoccupied with administrative levers and computer print-outs, at least some new team members indicate awareness that nothing will work without basic structural changes. Nevertheless, all face seriously the assignment to somehow toilet-train the health system costs prior to a full federal feeding of national health insurance.

Early Carter cost-cutting proposals are more liberal than those of the lame-duck Ford Administration. The latter's budget proposals for the next fiscal year, issued just before leaving office, sought cost reductions extraordinary even for its Scrooge-like stance. These would have required cost-sharing by elderly and poor Medicare recipients, presumably cutting their desperate, "unnecessary," utilization, and thus chopping away at rising costs. Ford would have imposed a seven percent "cap" on annual increases in hospital reimbursements, but only for Medicare patients. Ford also proposed to incorporate Medicaid funding into single block grants to states, making Medicaid totally dependent on independent state actions and clearly spelling heavier cutbacks for low-income medical programs.

Releasing its quickly revised budget proposals in late February, the Carter Administration cancelled the regressive Medicare cost-sharing and revealed its own cost control proposal aimed at all hospital reimbursements. Also gone was the Ford state block grant plan leaving Medicaid, for now, a categorical entitlement program for welfare beneficiaries. The Carter cost containment plan, scheduled to be developed and released in a few weeks, would establish "negotiated" prospective limits on hospital reimbursements from all sources—Medicare and Medicaid, Blue Cross, commercial insurers, and direct individual payments. A national or state-by-state ceiling on increases in reimbursement rates would be negotiated each year, starting with fiscal 1978 (beginning in October). Some advisors were reportedly urging immediate or retroactive controls to prevent hospitals from raising base charges in advance, but these seem unlikely.

How the Carter Administration will deal with the politics of health planning was previewed by Califano at a February 21 press conference: "How we go about preparing this legislation, and how we go about putting in place the hospital cost containment program are things that, at my request, are deliberately left open. I have already talked to some of the people involved, the head of the American Hospital Association, the head of Blue Cross, the head of the AMA, and we'll be talking to others as we put together the specifics of this program... a 7% increase [for next year] would take care of all projected wage increases and other costs. We threw in an extra 2%... for new equipment and that kind of thing..."

Reflecting the rather strained, low-expectation-style promises that typify Carter's new managers, Califano declared, "This administration will be compassionate as it serves the American people and efficient as it spends their tax dollars." The leading political survivor of the Johnson Administration's Wars on Poverty and on Indo-China claimed he was only a "lamb in the thicket" of medical costs. Within a week, however, it was disclosed that he earned $550,000 in 1975 as Edward Bennett Williams' law partner. The firm has 11
handled, among others, Pfizer Pharmaceutical, Coca-Cola, John Connally, Jimmy Hoffa and the \textit{Washington Post}.

For specifics of Carter Administration health goals, the Secretary pointed to a "compassionate" baby-step of $180 million toward "kiddie-kare" and to the "efficient" hospital cost containment proposal, though he dodged letting the latter be called federal price (or wage) controls.

\textbf{New Federal Faces}

Appointment of the Number One federal health official, the HEW Assistant Secretary for Health, has been delayed while the administration sorts through a list of mostly Democratic doctors. Meanwhile, Califano's chief health policy planner, Karen Davis, Deputy Director for Health, HEW Office of Planning and Evaluation, may best characterize the Carter Health Team's commitment and experience.

Born poor on an Oklahoma farm 34 years ago and educated in Texas, Davis comes most recently from the socio-economic shadow government, Washington's Brookings Institution, which published her \textit{National Health Insurance: Benefits, Costs and Consequences} in 1975. Henry Aaron, her boss as HEW Planning and Evaluation Director, is also from Brookings.

For the past couple of years Davis had been Co-Director (with Ray Marshall, University of Texas professor and now Secretary of Labor) of the Robert Wood Johnson Foundation-funded Southern Rural Health Project. She thus learned the limits of government and private medical insurance mechanisms at the practical level of rural and underserved communities.

Davis' savvy sensitivity, however, has not yet been reflected by any publicly-stated awareness of agencies of change other than enlightened bureaucracy and client communities. Though she has expressed the need for more environmental and public health programs, paramedical support, and direct community participation and control in rural situations, the obvious parallels of the "rural question" for the more numerous and politically explosive inner-city "underserved" have not been fully projected by either Davis or Marshall.

Her critically committed approach is suggested by Davis' speech to the recent convention of the American Association of Medical Colleges:

``... A positive reimbursement policy might: (a) encourage more efficient and responsive organizational arrangements for the delivery of health care services such as community-controlled comprehensive health centers, primary care centers, non-profit group health practices, health maintenance organizations, and others; (b) attract health professionals to underserved areas; (c) favor less costly ambulatory care rather than inpatient or institutional care; (d) encourage primary care practice rather than specialization; (e) encourage use of nonphysician health professionals where possible without lowering quality standards; (f) ensure that physicians and other health professionals are economically neutral with regard to choice of diagnostic testing and recommended therapeutic procedures; (g) penalize unnecessary or duplicative capital equipment and facilities; (h) create incentives for hospital administrators, medical staff and hospital personnel to contain hospital costs.''

The spectre of modern medical inflation and maldistribution is now an officially federal case. Some who know better and care more are now part of the clumsy federal machinery. Special interest politics-as-usual and the larger corporate need for new planning and controls are on a federal collision course within Carter's first Thousand Days.

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Robb Burlage and Len Rodberg
NURSES: DOUBLE SHIFT

Responding to mounting pressures on the profession, the American Nurses’ Association (ANA) in 1974 endorsed mandatory continuing education as a prerequisite for continued licensing of nurses. Although the ANA action does not have the force of law, the Association is promoting the concept to state affiliates, who in turn, are lobbying for the incorporation of such a provision in each state licensing law.

California was the first state to enact mandatory post-degree education for nurses (although difficulties in enforcement have, for the moment, put the regulation on the back burner). The New York State Nurses’ Association recently designated a catchall list of meetings, courses and seminars covering a potpourri of subjects to meet the criteria for continuing education. Registered or licensed practical nurses must register for at least 40 hours of this hodgepodge a year if they wish to keep their licenses.

While few would argue the need for better training and education, the ANA’s resolution and subsequent state actions will not necessarily benefit either nurses themselves or the patients they serve.

Pat Sejut, a nurse who worked in the field for 14 years, reflects on the impact of these education requirements and raises problems that may not be evident at first glance.

The great majority of rank-and-file nurses are hostile to mandatory continuing education. It is not that they are unwilling to learn more that would be of value to them in their profession. Far from it. But, nurses are worried about how they will fit continuing education into their lives if they are forced to do so.

For the young nurse the biggest problem will be finding the money to continue her education immediately after graduating from nursing school. For example, take the case of Ms. Brown. Since she comes from a large family, her parents were unable to pay her expenses during training. She relied heavily on financial aid and loans. Now, as a graduate, she is obliged to repay the money she borrowed. At this time in her life she is unable to handle the added expense of continuing education.

For the woman with young children, the biggest problem is likely to be time. For example, Ms. Johnson has four small children. She is an RN who works three nights a week on the three to eleven p.m. shift. She is overburdened with the roles of the all-American wife and mother during the daytime and the efficient nurse in the evening.

The older woman who has been in nursing for a number of years is usually a diploma school graduate. Her training was based more on the apprenticeship model than on classroom teaching. To these women, the idea of mandatory continuing education is often very threatening. It’s hard enough for recent high school graduates to adjust to the unfamiliar environment of the college classroom. But, for the older woman this adjustment can be devastating.

This prospect is so terrifying to many older women that they are considering leaving nursing. Ms. Wilson, for example, graduated from a diploma school in the early forties. She worked her way up through the ranks to a supervisory position. Along the way, she picked up many new skills and new procedures. Now, she is considering leaving the field rather than complying with the continuing education proposal.

Mandatory continuing education will also have an effect on the health care institutions. The large teaching hospitals affiliated with medical schools will probably be able to provide academic-level in-service training for their staff. But, what about the small unaffiliated hospital? If the nurses are expected to shoulder the entire cost through tuition, they will probably begin to look for jobs in institutions which can offer low-cost continuing education, and the small community hospital will suffer.

Another potential problem is staffing. If nurses are allowed to go to courses or lectures during working hours, this will put an additional burden on the remaining staff. As
It is now, in our hospital, when a nurse is selected to go to a lecture or seminar, the rest of the workers have to take on an extra workload.

The nurses' associations might argue that mandatory continuing education will be worth the price, because it will serve to elevate the standards and skills of nursing. But, such proposals for continuing education will not necessarily improve the quality of nursing care. If they were really interested in improving care, they would spell out what particular deficiencies in nursing skills and training they hope to remedy. All that the professional associations seem interested in is credentials for their own sake.

Who does stand to benefit from mandatory continuing education? First, the state nurses' associations. This proposal will greatly increase their power over the rank-and-file nurses. They would be in a position to determine how frequently licenses must be renewed and what the academic requirements for re-licensure would be. Another group which clearly stands to gain is the higher education establishment. In these days of dwindling college enrollments, what could be better than to force thousands of adults to seek college credits?

In my opinion, the nursing leadership is in fact beginning to act more and more like an arm of the higher education establishment than a representative of rank-and-file nurses. The leadership looks down on us. They see us as potential students to fill up their and others' courses. They are out of touch with our needs and concerns. At least, that's how it looks from the hospital floor.

**Notes From the Population Front**

The following news items, selected from isolated New York Times stories over the past six months, suggest how the population trends and policies of various nations respond more clearly to political and economic realities than the health needs of their publics:

India: Here, where family planning is a top national priority, seven million sterilizations were performed last year, mostly on men. This brings to twenty percent the number of couples now protected in some way against conception. (12/28/76)

Bangladesh: Sterilizations have risen to eight thousand a month—as many as there were in all of 1975. The number of couples who practice contraception or who have been sterilized has risen from four to seven percent. (9/30/76)

France: Authorities are worried about too few people. The population has been declining over the past ten years, in part because of the more general use of contraceptives and the availability of legal abortions. Some members of the government, linking French grandeur to population size, are considering policies which encourage women to have larger families. These include increasing the monthly aid and tax breaks given to families for every child after their first. (12/5/76)

Laos: In an effort to increase population, the government has banned the sale of all contraceptive devices. (9/9/76)

American Indians: The U.S. Indian Health Service sterilized 3,400 American Indian women between the ages of fifteen and forty-four over a four year period without telling many of them that the operations were not necessary and without obtaining proper consent. Thirty-six of the women were under the age of 21, despite a court-ordered moratorium on sterilizations of people under this age. (11/23/76)

—Adapted from HEALTHRIGHT

(HealthRight, Inc., 175 Fifth Avenue, New York, N.Y. 10010 is a women's health education and advocacy organization. Annual subscriptions to its quarterly newsletter are $5 for individuals or $10 for institutions.)
The directors of the New York City Health and Hospitals Corporation (HHC—the semi-public agency administering NYC’s municipal hospitals) voted 9-7 in a January 26 closed session to remove Dr. John L.S. Holloman as president effective April 30. The ouster followed nearly two years of pressure from union, city and state health and budget officials, as well as the all-powerful Emergency Financial Control Board (EFCB).

Holloman was elected by the HHC board in April, 1974, from 160 candidates as a “favorite son” of the city’s Black political establishment. Prominent Black physician, former president of the National Medical Association and long-time civil rights activist, Holloman’s election was viewed by some as a possible salvation for the municipal hospitals.

Over the next three years, Holloman pursued the sort of political style associated nationally with Eugene McCarthy. Maneuvering and strategizing among contending enemy factions, he more often than not failed to look back to see who was follow-

ing, while the troops themselves trickled down to a handful. In short, Holloman never developed a real political base among those he hoped to symbolize.

The results were predictable. Holloman’s campaign to save the public hospitals might be harshly summarized as three years of militant backsliding. As HHC president, he oversaw wide-ranging, drastic cuts in services and jobs throughout the system. Although he argues these would have been greater under a more compliant executive, the record of actual reductions is sobering: five closed hospitals, 8,000 jobs lost and a net reduction of $175 million from the $1 billion HHC budget.

The Countdown

The irony is that so much effort and energy was required to oust a man who, theoretically, could have provided the aura of legitimacy to dismantling the municipal hospital system. The chronology of events surrounding Holloman’s removal reveals that it had less to do with managerial incompetence or the dismal state of the municipal hospitals than with the current vicissitudes of NYC fiscal politics:

- Fall, 1976: Under steadily increasing pressure from the EFCB, Beame pushes hard for Holloman’s resignation. Long critical of Holloman’s managerial abilities, Beame “takes control” of HHC finances by appointing a committee under NYC budget director Donald D. Kummerfeld to draft a new HHC financial plan for submission to the EFCB in January.

- December, 1976: Kummerfeld’s committee recommends a two-year plan combining service reductions, work force attritions, tentative hospital closings and other economies with schemes to generate new revenues. The unspoken assumption behind the plan—less severe than an earlier Holloman/HHC proposal rejected by the EFCB—is that the EFCB will buy it, if combined with Holloman’s ouster.

- January 12, 1977: HHC’s board approves the plan; Kummerfeld predicts acceptance; the EFCB schedules consideration later in the month.

- January 20: Governor Carey’s new budget proposes even more drastic Medicaid cuts, confronting City Hall with greater HHC deficits and dousing hopes for new revenues at the state level. The City’s and HHC’s last hope for approval of the Kummerfeld plan—that dumping Holloman will appease the EFCB sufficiently to win approval—becomes the number one priority. Beame increases the pressure; Holloman feverishly seeks Black political support. Manhattan Borough President Percy Sutton, about to announce his mayoral candidacy, says Holloman’s fate will not be a major campaign issue.

- January 25: Holloman wins last-minute public endorsement from Sutton, three Democratic US Representatives—Herman Badillo, Shirley Chisholm and...
Charles Rangel—and Bella Abzug.

Beame, meanwhile, sends a letter to HHC board members indicating Holloman “cannot count on the continuing support” of city or state officials. As if to amplify his remarks, Dr. Pascal J. Imperato, newly-appointed city health commissioner and HHC board chairman, tells a New York Times editorial luncheon that Holloman lacks the “managerial ability to head an enormous corporation,” adding, “you can’t run a $1 billion corporation with 95 percent heart and only 5 percent administrative ability.”

Somewhat ominously, Imperato proceeds to suggest the HHC be abolished and replaced by the type of hospitals department it replaced in 1970. On community opposition, he concludes, “What the community perceives as needs often are simply wants.”

* January 26: In a hurriedly-called session, HHC directors finally vote to fire Holloman. Attention is focused on William Michelson, DC 37’s representative on the board, and on the board’s minority members. Michelson votes against Holloman. Despite intense arm-twisting during the preceding days by Mayor Beame, two of his Black appointees—Deputy Mayor Paul Gibson and Mental Health Commissioner June Christmas—support Holloman. Dr. Frank Folk, reportedly seeking a lucrative city appointment, is the only Black board member voting against Holloman; Dr. Elena Padilla, the sole Puerto Rican on the board, also votes for Holloman’s ouster.

* January 28: The EFCB considers the Kummerfeld proposal, notes Holloman’s demise, and is yet not pleased. It recommends that the HHC propose more specific plans for savings.

* February 25: Meeting in public session, the EFCB adopts and sends to the HHC a resolution demanding $66 million in new budget cuts, a demand likely to mandate further closings and economies.

The Questions... And Some Lessons

Holloman’s own explanation of his demise is straightforward: “The question isn’t a problem of mismanagement,” he recently told a student group, “but a question of unmanageability. And the problem was that I wasn’t manageable.” Given his actual record, however, this clearly falls short of an ultimate explanation for the remarkable importance attached by state and city officials to his departure.

Part of Holloman’s trouble clearly did lie with the task of defending the HHC at all, a job described by one possible replacement candidate as having “one chance in a million” of success.

Meanwhile, an immediate lesson from the dumping of John Holloman is that it represents one of the rare but always historic occasions in political life when what a public official said may have been more important than what he did. Willing to compromise when necessary, Holloman was nevertheless notable for repeatedly insisting in public that “Health Care is a Right!”

In the city’s chilling new political climate — with a kind of economic martial law replacing the familiarities of the old clubhouse corruption — John Holloman was simply guilty of using language unbecoming to an officer. His “court-martial”—or drumming out—thus became an object lesson for any official that the minimum service he or she must provide is lip service.

But there is a larger lesson as well. For the one million New Yorkers entirely dependent on public hospitals and for the remaining 37,000 workers in them, the futility of depending upon symbolic leadership by public officials lacking in grassroots support or real programs has never been more clear.

John Holloman realized he lacked a political constituency far too late — long after most of the community residents and hospital workers who might have supported him grew weary from being ignored, rebuffed, maltreated and laid-off in the very hospitals he was trying to save. The result — tragically enough for all concerned — is that John Holloman’s dream became a mirage.

—Michael Clark
STATES' WRONGS

Fears that the occupational health and safety effort in this country may be in deep trouble were fanned by a recent report to Congress by its watchdog agency, the Government Accounting Office (GAO).

Critics of the federal Occupational Safety and Health Act (OSHA) have long contended that recent advances in worker health and safety would be erased if states take over OSHA enforcement from the federal government, as the law provides. Now, with 24 state plans approved by the US Secretary of Labor and 15 more awaiting approval, the GAO has made a slashing attack on the effectiveness of state enforcement in its report, "States' Protection of Workers Needs Improvement."

Central to the GAO critique is a gaping loophole in the OSHA law itself, one which most critics had previously overlooked. A state plan, in order to gain approval by the US Secretary of Labor, must provide for state standards and enforcement that, in the words of the law, "are or will be as effective" as the federal government's (our emphasis). Thus, the GAO notes, "states may meet these criteria by merely including provisions in plans for future development and adoption of authority, standards, enforcement procedures" (GAO emphasis).

This loophole is large enough to drive a train through; the GAO study shows that most states have already done just that. Not a single one of the approved state plans is as effective as the federal law, according to the report. The GAO found deficiencies in the legal authority, standards and/or enforcement procedures of all approved state plans. For example:

- New York State inspectors carried out over a third of a million inspections in 1974, uncovering 300,000 violations, but were helpless to levy fines since the State plan failed to authorize any penalties for violations. (New York has since withdrawn its state plan.)
- The Washington State plan did not require penalties, as the federal law does, when an employer failed to correct a violation in the assigned time period. What is more, the State prohibited its inspectors from setting abatement periods of less than 16 days for correction of violations. Consequently one employer was given 20 days to move a crane boom away from nearby overhead cables, which could presumably have electrocuted the operator if the crane touched them. Another employer was given 16 days to stop using a cutting torch on flammable bottles. In both cases, according to the GAO, federal OSHA inspectors said they would have required immediate correction of the hazards.
- South Carolina omitted from its state plan a standard "general-duty clause"—that each employer furnish employees with workplaces free from recognized hazards. Such a provision allows inspectors to cite and require elimination of obvious hazards even when no explicit standard exists to cover the situation. It thus legally recognizes that no set of written standards can possibly cover all industrial situations. In the absence of this provision, five workers were killed in separate accidents in South Carolina, but the hazards that killed them were not eliminated. In each case, according to the GAO, federal OSHA inspectors said they would have invoked the general-duty clause to prevent further worker deaths from the same hazards.
- Federal OSHA inspectors, investigating nearly 200 case files in Washington State, found 25 percent with violations improperly classified by state inspectors.
- In Oregon in 1974, federal OSHA inspectors, accompanying state inspectors for "on-the-job evaluations," found 75 serious violations and 726 non-serious violations which the state inspectors had missed (out of an unspecified total number found by the state). These included many hazards potentially harmful to employees, the GAO said:
  "— Workers were exposed to unguarded saws.
  "— Workers were not protected from falling into an open vat filled with liquid salt heated to 1,500 degrees Fahrenheit. Employees were observed standing beside the vat."
"— Blasting powder and blasting caps were not separated to prevent accidental detonation."

Not a single one of these violations was cited by OSHA, the GAO added. According to federal OSHA guidelines then in force (they've been changed in the wake of the GAO report), the federal OSHA inspector was instructed to tell the State inspector of his or her oversights privately, after the inspection, meaning in practice that the violation was not cited by state or federal agencies. Clearly the federal agency's first loyalty in this case was to the state inspector, not the worker who might be injured or made ill.

**OSHA Defends Itself**

The US Labor Department's Occupational Safety and Health Administration, major target of the GAO attack, defends itself in a letter appended to the GAO report. The shortcomings observed by the GAO, it contends, are "no longer applicable;" most have already been eliminated. The Labor Department notes, for example, that two of the six states studied intensively by the GAO—New York and New Jersey—have withdrawn their state plans and that South Carolina now has a general-duty clause in its state plan.

Under any circumstance, the Labor Department notes, the federal government for the moment retains its authority to inspect workplaces and compensate for major failings of state plans, since the law provides for a three year development period following initial approval of a state plan, during which state and federal agencies share authority. Afterwards, the Labor Department has up to two more years to evaluate state plans before giving them final approval, at which point states assume sole authority for occupational health and safety enforcement.

Neither of these arguments will give comfort to those concerned about further weakening of health and safety in the workplace. In a period when OSHA is under heavy public attack from business and industry groups, major political restraints mitigate against the Administration withdrawing approval of state plans—plans that have been functioning for anywhere from three to five years. More important, while many specific deficiencies cited by the GAO may have been eliminated, the most disturbing aspect of the report is the widespread pattern of state noncompliance with the federal OSHA law. This pattern certainly will not change without a total revamping of state laws, a prospect about as likely as AMA support for a national health service.

(Copies of the report can be obtained for $1 from USGAO, Distribution Section, P.O. Box 1020, Washington, D.C. 20013. Copies of the report, free of charge, are available to students, faculty, college libraries and press, as well as government officials, from USGAO, Distribution Section, Room 4522, 441 G Street, N.W., Washington, D.C. 20548.)

—David Kotelchuck
Occupational Physicians
(Continued from p. 10)

consumer, has abdicated its role by demanding that the government instead of industry take on the functions of determining the scope, organization and administration of medical service.\(^{11}\)

Talk of responding "to both forces" and creating a medical practice reflecting an "interplay between the two" is empty rhetoric. It flies in the face of companies' major goals in hiring occupational physicians: keeping Workmen's Compensation claims, insurance premiums and lost time to a minimum. Far from having neglected to compromise and modify labor's health care demands, industry's successes in this area have been considerable. Indeed, the resulting neglect and damage to the health and lives of American workers have produced a virtual crescendo of worker demands for government intervention.

Later on in the same lecture, Tabershaw had the temerity to claim that "As health delivery systems are developed which include the entire population, nonoccupational physicians will find it convenient (out of ignorance) to blame many more illnesses on stresses of work and the environment. Occupational physicians will become increasingly defensive in order to demonstrate that while work and the environment play a greater part than have up to now been attributed to them, they are by no means the major determinants of most illnesses."\(^{12}\)

With most areas of occupational health begging for research funds and qualified personnel, and with new environmental causes of disease being recognized almost daily, it is difficult to understand why an occupational physician in the 1970's would be concerned about the possibility of too many illnesses being blamed on the work environment.

The impression of occupational medicine as a dull and repetitive specialty is largely a result of the emphasis on providing physicians for in-plant medical care. A large part of an in-plant physician's time is spent on routine physical examinations, completing insurance and compensation forms, and testifying in compensation cases. Many industries reinforce this pattern by their attitude toward continuing education and training. Companies rarely require their physicians to have board certification; some are even unwilling to grant their doctors leave for an academic year's training to earn the equivalent of a Master's degree in Public Health. For most companies, occasional, short courses of a week or less are considered sufficient.

Perhaps the greatest potential value of the occupational physician—developing and implementing preventive health programs, including medical and epidemiologic surveillance and monitoring—has generally been ignored by industry.

Considering that most practising occupational physicians are supported during their training and then employed by industry, it is easy to understand why workers look on them as guardians of industry's interests. Dr. W. Clark Cooper, former director of the Bureau of Occupational Safety and Health (OSHA's predecessor), concedes that in-plant physicians who see themselves as workers' doctors and not industry doctors have been "in the minority." He places a large measure of the blame on the occupational physician's involvement with Workmen's Compensation.

"We are not going to get the relationship between the physicians, the company and the workers on a proper professional basis as long as the physician is identified too closely with the company . . . ."

— W. Clark Cooper
former Director, Bureau of Occupational Safety and Health

**We are not going to get the relationship between the physicians, the company and the workers on a proper professional basis as long as the physician is identified too closely with the company . . . .**
identified too closely with the company, and appears as an adversary to his patient, in the area of Workmen's Compensation,” Cooper says. In his opinion, compensation for disability regardless of cause would liberate the physician.

The occupational physician’s ability to serve the broader health needs of workers is also discouraged by limits on the in-plant physician’s scope of practice. The AMA, in its brochure entitled “Scope, Objectives and Functions of Occupational Health Programs,” states:

“There are two types of health programs for those who work. The one that is dealt with in this statement is the occupational health program that deals with the health of employees in relation to their work and is largely preventive. The other type is a medical care program for non-occupational illnesses and injuries. These two types of programs differ in such respects as methods of financing and amounts and kinds of services. Failure on the part of employers, employees and physicians properly to distinguish between these two types of programs sometimes give rise to misunderstandings and problems, particularly in those few situations in which the same professional personnel serve both programs.” (13)

Thus, occupational physicians have traditionally viewed treatment of non-occupational medical societies, the company doctor, and the company, and none will be available to workers’ families.)

The Need For Reforms

An example of possible reforms in established occupational medicine is suggested by Jacob Clayman, Secretary-Treasurer of the AFL-CIO’s Industrial Union Department. According to Clayman, the country acutely needs to increase the number of “occupational medical scientists to determine as quickly as possible what dangers the thousands of industrial chemicals hold for workers who are exposed.” He calls for
federal grants to colleges and medical schools to broaden the field of occupational medicine.

"We’ve got to provide opportunities for doctors to work in this area and make it profitable to do it," Clayman says. "Aside from working in public institutions and hospitals, they’ve got to be on the staffs of state and private universities with opportunities to continue research, drawn into agencies of state and federal governments to perform service for the public generally."

Concerning the role of organized labor in creating these new jobs, Clayman is pessimistic. "I don’t see the labor movement absorbing meaningful numbers of occupational physicians in the foreseeable future. If government doesn’t do it, it’ll be a long time before we fill this obvious need."

Whether or not it is likely, the hiring of occupational physicians by unions would seem to be an inappropriate solution to the stagnation of occupational medicine in the US. The nature of union structure suggests that such physicians would be absorbed into union bureaucracies without any real ability to meet the needs of workers at their worksites. Meanwhile, a more desirable goal is struggle by unions through collective bargaining to achieve worker control of medical services at the workplace—which, as Clayman says, is going to be a long while coming on any significant scale.

Clayman suggests that prepaid medical groups should be staffed with occupational physicians since many such groups were started and are largely supported by organized labor. But, he stresses, the needs of unorganized workers should not be forgotten. Responsibility for them lies "on the doorstep of Government, and then medical schools and universities, who so far have offered no leadership." Other trade union leaders have suggested occupational physicians should be employed by non-commercial insurance carriers as consultants to labor unions, since identification of the causes of industrial disease would benefit these carriers as well as workers.

The needs for other occupational health specialists such as epidemiologists and medically-oriented biostatisticians could probably be met by expanded recruitment within universities. A major reason why such a large percentage of young doctors leave occupational medicine after their first year of residency seems to be the desire for more clinically-oriented work. Rather than trying to lure them away from clinical medicine,

"I don’t see the labor movement absorbing meaningful numbers of occupational physicians in the foreseeable future. If the government doesn’t do it, it’ll be a long time before we fill this obvious need."

— Jacob Clayman
Secretary-Treasurer, AFL-CIO’s
Industrial Union Department

which attracted many to medical training in the first place, future epidemiologists and biostatisticians might more rationally be recruited from among undergraduate mathematics and science students and geared toward doctoral programs in occupational health. Epidemiologists, for example, do not require an M.D. degree. Similarly, the necessary paramedical personnel for an expanded occupational health labor force would need relatively little training beyond what they now get in order to enter the field.

In order to meet health care needs in a technological society, services in occupational and preventive medicine must be provided. If the Federal Government does not support training, education and jobs in occupational medicine, the field by necessity will continue to focus on providing service to private industry rather than to the public. With Government support, occupational medicine could be upgraded and its objectives redefined. If broader job opportunities were made available, more people would be attracted to the field and
The Oil, Chemical and Atomic Workers International Union (OCAW) has approximately 200,000 members in this country and Canada, who are exposed to thousands of hazardous substances, ranging from radioactive materials to noxious chemicals, dusts and fumes.

Because of the disastrous health experience of its workers, and because most pollutants are emitted from the plant environment into the community at large, the OCAW has made occupational health and safety one of its major concerns, and, under the leadership of International Union President A.F. Grospiron, has played a prominent role in the field. In the Health and Safety Department at union headquarters in Denver, and at the Citizenship-Legislative Office in Washington, D.C., there is an ongoing program of health and safety publications, investigations, seminars and training institutes for workers, and, most recently, a medical student-resident internship program.

In May, 1976 the Union, through its Legislative Department, instituted a national educational program of occupational health training for medical students and residents. The purpose of the program is threefold: to study disease patterns associated with industrial processes; to gather and analyze data on specific industrial health problems; and to assist rank-and-file workers in developing preventive occupational health programs.

To assure broad participation, the union has tailored the program to qualify as an elective in the curricula of medical schools, public health schools and hospitals.

A pilot project was carried out with four students from Albert Einstein College of Medicine in New York City, with the faculty of the College's Department of Community Health and of the Department of Social Medicine at Montefiore Hospital acting as consultants. The students, assigned by the union to OCAW workers at a plant in the vicinity, conducted a thorough investigation of the plant layout, work processes, worker-exposure to chemical and physical agents, and worker health histories. Their findings, together with recommendations for immediate and follow-up action, served as a catalyst for the workers to institute an on-going occupational health program at the plant, and for the union to ask a major medical investigator to consult on health problems identified by the students. Similar efforts have recently been carried out with students and interns at Harvard School of Public Health, Johns Hopkins School of Medicine and Baltimore City Hospital.

OCAW is now soliciting participation of more medical schools and hospitals. The program will run continuously throughout the year, with students spending approximately eight weeks on a project. Flexibility is allowed to meet the needs of students who have less (or more) time to devote. Ultimately, students on rotation will replace each other on particular projects, so that work begun by one group will be continued by another.

The program will include a week-long orientation seminar for students, conducted by the project director, with a faculty comprised of medical academics and workers. Orientation will cover basic problems of health and safety as well as the workings of the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH). Methods of gathering data, taking case histories and other techniques will be included. Selected union locals will be briefed by the OCAW.
program supervisors about the educational program, its goals and purposes and will participate in designing projects for their particular situations.

After this general orientation seminar, students will go to union locals for local orientation on the projects. Local union members will serve as part of the orientation faculty, together with program supervisors and medical faculty from participating medical institutions.

Local union members and students will begin by gathering data about the factory and the local, as well as the economics of the industry, the history of the factory in the community, and general anecdotal information about the health experience of the local members.

This work, which will last approximately three weeks, with two to four students working full time, will be closely supervised by the field work faculty, making sure that the methods used blend with the needs of the particular local and establish a structure which will enable the project to continue. The students will inform the union of everything they do and are planning to do, so that the local will be able to carry on the project when the students leave.

A preliminary report will be required describing the general production process of the factory, the materials used, at what point in the production process they are used, and general information on workers’ job responsibilities. The report will include recommendations and a design for systematic study of the problems at that work site, as well as plans for an educational program. The project director, consulting medical professionals and the International will evaluate the report and recommendations.

Next, local union members and students will conduct a joint educational program for workers, to include health education about the human body and how it can be affected by the work environment, the OSHA law in relation to the particular work environment being studied, and special programs designed specifically for health and safety problems relating to that factory. This will give workers necessary information to establish further health education programs within their local, and will teach them how to utilize medical schools and health resources in their localities.

Concurrent with the educational program, the students will begin systematic study of health hazards in the workplace, using questionnaires to compile work histories on all workers at the factory, including their exposures to chemicals, dusts and fumes. In consultation with medical faculty, this data will be analyzed and a medical testing program designed. Students will also carry out epidemiological studies where feasible and necessary, utilizing the services of local union members, as much as possible, to conduct surveys and collect mortality and morbidity data. When biochemical tests are required and the project participants are not licensed physicians, the project director will recruit physicians to do the tests.

When the study is completed, all data will be analyzed and fed back to the union and to the individual workers. Then the OCAW, medical professionals, project coordinators, students and local union members will consult together to determine the next step in improving health and safety conditions at the factory.

For further information call or write Anthony Mazzocchi, Citizenship-Legislative Director, Oil, Chemical and Atomic Workers International Union, 1126 16th Street, N.W., Washington, D.C. 20036. Phone (202) 223-5771.
occupational physicians might enjoy the status accorded impartial scientists. Medicine must be taken out of the area of private enterprise and moved into the realm of public service. —Susan Mazzocchi

(Susan Mazzocchi worked with Dr. Irving Selikoff of the Environmental Sciences Laboratory, Mt. Sinai School of Medicine, as a field researcher and is currently writing a book documenting the history of worker involvement in occupational health struggles.)

References

8. Ibid., p. 9.
9. Interview with Dr. Paul H. Thean, NIOSH, Division of Training and Manpower (July 15, 1976).

Health/PAC Sustainers Report

Early response has been very enthusiastic to the Health/PAC Sustainers Program. One benefit is already reflected in the expanded format of this BULLETIN.

We are grateful to all of you who have responded so far, and we are struggling to reply to each of you individually. If you haven't sent your contribution, please do so today.

The Health/PAC Staff

Health/PAC, 17 Murray Street, New York, New York 10007
Vital Signs

Mechanical vs Human Fetal Monitors

Are fetal monitoring devices more effective than good nursing care during childbirth? A recent, prospective study of 483 randomly-selected, high-risk births found no differences in the standard Apgar scores or cord blood gases of the infants, nor in the neonatal nursery morbidity or neonatal death rates of those who were monitored during delivery compared to those who were followed closely by a nurse. While there appeared to be no difference in outcomes for the infant, the study, conducted by the University of Colorado, did find differences for the mother: the rate of caesarian sections was much higher when the fetal monitor was used (16.5 percent compared with 6.6 percent).

(Medical World News, December 13, 1976)

AAMC: Up Against the Wall

"The entire private sector system of accrediting higher education may crumble," warns John A.D. Cooper, M.D., president of the American Association of Medical Colleges (AAMC), "if the involvement of the concerned profession can be so easily challenged."

What has Dr. Cooper so agitated is a threatened Federal Trade Commission (FTC) suit against the Liaison Committee on Medical Education (LCME) for restraint of trade. The LCME is the legally sanctioned accreditation agency for all US medical schools. This august private body is composed of six representatives of the American Medical Association (AMA), six representatives of the AAMC, one representative of the federal government and two so-called public members, appointed by the rest in secret session.

The LCME is especially vulnerable to the antitrust charge since throughout its history it has actively sought to maintain medicine as a closed shop. Created by the AMA in 1906, its first important act was to sponsor the investigations of medical education in the US conducted by Abraham Flexner. Within ten years, 70 of the 185 medical schools in the US had been shut down. Since 1943, when the AAMC was added to the committee, no one has successfully challenged the right of medicine to control access to its profession.

But times do change. In a letter to education officials last November, Daniel Schwartz, acting director of the FTC's Bureau of Competition, charged the LCME with "a conflict of interest inappropriate for an accrediting agency." Schwartz argued that this conflict stems from the participation of the AMA. Since the AMA, according to Schwartz, "vigorously pursues the economic interests of its members," it has a vested interest in curtailing the supply of doctors and in keeping the practice of medicine a sellers' market.

The medical establishment is running out of vocabulary to express its outrage at various government assaults on its imperial prerogatives. After waging a largely unsuccessful battle against federal inter-
vention in medical school admissions and curricula, the AMA and the AAMC once more find themselves against the wall. The FTC has trained its guns on the AMA because in the gallery of national politics they are a lesser mark. But the more powerful AAMC fears the same fate if the FTC suit against the AMA is successful.

## A Czar Is Born

New York Governor Hugh Carey, in his annual health message to the state legislature, has called for a new, top-level administrator with "full authority" over New York City's entire health care system, including power to close both municipal and voluntary hospitals. The new "health czar" position would, in many respects, supersede both the present Health Commissioner and Health and Hospitals Corporation President.

New York Mayor Abraham Beame has agreed to such a post, according to a February 19 statement by Deputy Mayor John Zuccotti, adding that he and the Governor were in "conceptual agreement" that such an official must be a joint city-state appointment.

The proposal for a health czar evidently originated from the Governor's key health advisor, Dr. Kevin M. Cahill, and from Stephen Berger, executive director of the Emergency Financial Control Board, the state's quasi-private overseer of New York City finances. According to Berger, one beauty of the plan for the Mayor and Governor is that the person "would take the heat, and both public officeholders would be in a position to step back."

Berger added that in his view the new administrator should be a person "equally well liked and disliked by both the municipal hospitals and the voluntaries, regarded by both with equal trust and equal fear, able to redesign the health system with rough equity and rough justice. He has to be a czar."

### Surgical Risk: Money is Everything

What aspects of hospital care most affect surgical outcome? A massive study conducted by Stanford University finds the strongest correlates of good surgical care to be: (1) expenditures per patient, (2) the proportion of RNs involved in direct patient care, and (3) the care the hospital takes in granting staff privileges. These factors far outweigh more conventional ones such as the size of the hospital, whether or not it is a teaching hospital, and the percentage of its staff that is board certified. Another study reported earlier in the year (part of the massive, five-year Study of Surgical Services in the US) found half of all surgical complications and 35 percent of all surgical death to be preventable.

(Medical World News, January 10, 1976)

### Financial Assistance to Medical Schools: Decapitating Deans

To hear the medical school deans tell it, the feds have gone too far this time. With the requirement in the new health manpower legislation that medical schools receiving student assistance monies accept third year American medical students trained a-

broad, some deans want to draw the line. Dean Clayton Rich says he will recommend that Stanford University turn away some $800,000 annually rather than "compromise important academic principles." Likewise Indiana University will turn down some $1.5 million a year and St. Louis University will pass up some $508,000 a year, if their respective deans have their way.

(The federal government pays $2000 in assistance per year per student to medical schools.)

There are currently 4000 Americans studying in foreign medical schools (compared to 57,000 here), who will presumably be offered the option of returning to US medical schools in their third year. How well lofty academic principle holds out against cold, hard cash remains to be seen.

(Medical World News, December 13, 1976)

### OSHA Enforcement Ruled Unconstitutional

A three-judge federal district court in Boise, Idaho delivered a bodyblow to the federal Occupational Safety and Health Act (OSHA) in a recent decision which unanimously declared a key enforcement provision of the Act unconstitutional. Specifically, the court held that the Act's provision for workplace inspections, without a search warrant based on probable cause, was a violation of the Fourth Amendment to the Constitution.

The ruling in the case, brought by a Pocatello, Idaho contractor, is one of the first constitutional challenges to OSHA that have been upheld in the lower courts and would appear to bar all inspection
activity under the Act. OSHA has gotten a temporary order from Supreme Court Justice Rehnquist allowing continued OSHA inspections pending a direct appeal to the US Supreme Court.

Nevertheless, if the Idaho decision is upheld, the OSHA law as it is now administered would essentially become inoperative.

ANNOUNCEMENTS

Vicente Navarro, editor of the International Journal of Health Services, has written a new book entitled Medicine Under Capitalism, in which he argues that a basic connection exists between the ideology, content and organization of medicine and contemporary capitalism—that capitalism, social class and class struggle, far from having been transcended, are at the very center of our understanding of the medical system.

Copies may be ordered from PRODIST, Neale Watson Academic Publications, Inc., 156 Fifth Avenue, New York, NY 10010. Individual orders must be prepaid at a cost of $5.95 (paperbound) or $12.95 (clothbound). (Checks and money orders should be made out to Neale Watson Academic Publications.)

BOOKS RECEIVED


Arelander, Herman (translated by Hella Freud Bernays), The Initial Interview in Psychotherapy (New York: Human Sciences Press) $13.95.


Burke, Kathleen M., Evaluation of the Quality of Medical Care: An Annotated Bibliography (Blue Cross of Western Pennsylvania).


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Greene, Richard, M.D., Assuring Quality in Medical Care: The State of the Art (Cambridge: Ballinger) $17.50.


Monteiro, Lois, Monitoring Health Status, and Medical Care (Cambridge: Ballinger, 1976) $17.50.

Mulhern, John and Momeny, Greer, eds., A Career in Primary Care (Cambridge: Ballinger) $15.00.


Proger, Samuel and Williams, Greer, eds., A Career in Primary Care (Cambridge: Ballinger) $15.00.


Szasz, Thomas, Heresies (Garden City, N.Y.: Anchor Press, 1976) $2.95.


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