To the Editor:
In a previous Bulletin (Volume 13, Number 1) I joined with two other Board members to debate who should control the dispensing of prescription drugs. I maintained (and still do) that the first step is to limit the availability of prescription drugs to only those proven safe and efficacious—a standard that many of today's marketed drugs would fail to meet. I believe that the recent experience with Benoxaprofen (Oraflex) serves to strengthen my argument.

Oraflex is a drug that was tested and used in England for some time prior to its approval last spring for marketing here. Six months later, clinical data published in the U.K. indicated a suspected causal connection between administration of the drug in elderly patients and their deaths from jaundice. Subsequent reports showed deaths in this country as well. The drug was voluntarily withdrawn from the market this fall by its manufacturer, Eli Lilly, after more than 60 deaths thought to be related to its use.

Despite this tragedy, Secretary of Health and Human Services Richard Schweiker is flowing with the deregulatory tide out of Washington, proposing new Food and Drug Administration regulations which would, among other things, relax the requirement that U.S. laboratory and clinical results are necessary before approval of any drug. Without deprecating the quality of European researchers, it is a fact that no other country has imposed standards as rigorous as those of the FDA.

I believe that the Oraflex experience as well as similar ones in the past mandate stronger regulation of the use and marketing of prescription drugs in the United States. There is no way that the consuming public could have known about the risks of Oraflex and made informed choices. Indeed the promise of relief from intractable arthritis pain led many consumers to request the drug and rally to support it even after the evidence of drug-related deaths had been publicized. Physicians were more than willing to dispense this FDA-approved drug, which appeared to break new ground in pharmacological treatment of arthritis.

Before deciding who should have the keys to the drug cabinet, there must be rigorous and enforced standards of safety and efficacy. Then, and only then, should the cabinet be unlocked so that citizens can make their own therapeutic choices.

Arthur A. Levin
Health/PAC Editorial Board member

(continued on page 4)
Notes & Comment

There's never been a fire sale in the profitable asbestos industry, and no one was surprised when the lawyer who went into bankruptcy court for the Manville Corporation (formerly Johns-Manville) admitted that he had never filed for a company “with a balance sheet which looked so good.”

“Nothing is wrong with our business,” declared company president John McKinney the day after filing under Chapter 11 last August, “Thousands of asbestos-health law suits are the problem.” This is quite a problem. So far over 16,000 suits have been filed and the company anticipates twice that many more. At the current average settlement of $40,000, the company complains, most of its $2 billion in assets would be drained away.

What a terrible tragedy to befall a healthy industry’s leading company, whose management was just trying to make an honest dollar. “Here’s the bottom line,” explained McKinney, “Not until 1964 was it known that excessive exposure to asbestos fiber released from asbestos-containing insulation products can sometimes cause certain lung diseases.”

This was often the story presented in the press. The shabby truth is readily available in the public record:
- In 1918 commercial insurance companies in the U.S. and Canada stopped selling life insurance to individual asbestos workers.
- The first medical report published in English on a death due to asbestosis lung disease appeared in England in 1924. Almost a dozen more appeared there in the 1920’s.
- In 1931 the British government placed asbestosis under its workers compensation laws.
- The first medical report of a lung cancer death caused by asbestos was published in the U.S. in 1935. Similar reports followed over the next two decades.
- By 1960, a total of 63 reports on asbestos-related diseases had been published in medical journals in the U.S., Great Britain, and Canada. Of these 52 indicted asbestos as a

Letter from the Editor

As any reader of progressive magazines is aware, this has been a hard year for an endangered species. Pounded by cost inflation, bled by the recession, and strangled by postal rate increases, independent, socially conscious publications rarely have wealthy advertisers or patrons to succor them.

Since the Health/PAC Bulletin has survived, we would like to take this opportunity to thank those who have made this possible. The Samuel J. Rubin Foundation, whose two year grant in 1980 gave us a little breathing space by partially funding an editor’s salary. The Adco Foundation, which has provided a relatively small but crucial grant for operating expenses. Carl Blumenthal, who aside from doing invaluable research on health cutback monitoring spent many unpaid hours doing layout and pasteup over the past year. Kate Plfordrasher, who has put in many hours on graphics without pay. Debra DePalma, who is paid as Executive Director but nowhere near enough for the work she does. Our writers, who have contributed their work free of charge. The Health/PAC Sustainers, who contribute $10 a month. And, lastly, you, our subscribers, who have been renewing at a rate which would make any magazine grateful.

The Bulletin is currently surviving with little grant money, no very large donations, and virtually no advertising. We’re proud of this hardiness, but it would be less than honest to say we are as secure about our publication’s future as the publishers of Time are about the future of theirs. We welcome your continued and enhanced support as Sustainers, subscribers, purchasers of gift subscriptions, and readers who recommend the Bulletin to your friends, students, coworkers, and libraries.

Jon Steinberg
cause of asbestosis, lung cancer, or both. The other 11, which concluded that asbestos did not cause lung cancer and that asbestosis was never or no longer a serious health problem, were all funded by the industry — mostly by Johns-Manville.

Not only was Manville putting out hard cash to provide a scientific denial of the truth, internal documents released during many recent trials reveal that management was well aware it was engaged in a coverup:

• In 1949, Corporate Medical Director Kenneth W. Smith sent a memo to his corporate superiors following a clinical examination of a large group of workers saying in part, "The fibrosis of this disease is irreversible and permanent so that eventually compensation will be paid to each of the men."

• In 1958, during a corporate medical conference about workers with abnormal X-rays in the transite water pipe department, one company doctor said, "We can put transite pipe out of business with this list of workers alone."

Throughout this period Manville workers were told nothing about the possible causes of their poor health until they had obvious symptoms or became disabled. Thus Dr. Smith said in the 1949 memo:

"It must be remembered that although these men have the x-ray evidence of asbestosis, they are working today and definitely are not disabled from asbestosis. They have not been told of the diagnosis for it is felt that as long as the man feels well, is happy at home and at work, and his physical condition remains good, nothing should be said. When he becomes disabled and sick, then the diagnosis should be made and the [compensation] claim submitted by the Company." (Smith’s emphasis)

(Continued from page 2)

To the Editor:

The article “Billions From Band-aids” on medical supplies contained a great deal of fascinating material, but I remain unclear as to the remedy proposed. Granted, it would be better to spend more money on primary care, but someone requiring sophisticated surgery or other treatment is certainly grateful to know that the instruments available now are superior to those of ten years ago. Are you saying that you would somehow limit the market to small, innovative firms? That you would call a moratorium on all research, development, and sales until basic health needs are met? Is there any country in the world that you think is doing a better job than the U.S.?

These are certainly big questions, but Health/PAC should at least try to provide some answers.

James Caven
Brooklyn, New York

To the Editor:

Your interview with Dr. Katherine Lobach was extremely moving as well as informative. I hope you will have more such pieces in the future.

Susan Taylor
Memphis, Tennessee

(continued on back cover)
**Vital Signs**

**High-Tec Medicine**

One never knows what will arrive next in the U.S. Mail. Recently, doctors received portraits from William H. Webster, Director of the F.B.I.,—suitable for Post Office framing—of suspect fugitives of the Weather Underground and their children. Along with them was an admonition to be on the lookout for parents “conscientious in seeking medical attention for their children” but who “seem to prefer”...nurses and midwives during childbirth....Another important clue might be their “nondescriptive automobiles ... kept in excellent mechanical condition...with wide angle mirror systems....” They are known for keeping German Shepherds and guinea hens as pets and sending their children to school. Another tip is that the children are “prone to ear infections” and “allergic to penicillin.” Most suspicious of all, the suspects’ “bills and other financial obligations are paid in cash or bank money order regardless of the amount.”

So the next time you visit your doctor or neighborhood health center, don’t be surprised if you see that the mug shots of the F.B.I.’s Most Wanted lists have replaced the diplomas and health posters. And don’t be surprised when you’re reported to the F.B.I. for paying your bill in cash.

*Hal Strelnick*

**Cutting Public Waste**

In our last issue we noted that the Reagan Administration was permitting Medicare reimbursement for anti-union hospital consultancy fees in a reversal of Carter Administration policy.

Quiet but effective lobbying by labor groups has saved the taxpayers the cost of this subsidy through an amendment to the Reagan tax bill expressly forbidding it. The American Hospital Association is going to court in an effort to bring back the payments by challenging the constitutionality of the ban.

John Sweeney, president of the Service Employees International Union (SEIU), the largest hospital workers union, thinks their case is weak: “As a union, we pay our own costs for conducting organizing campaigns and the healthcare institutions should pay their own costs for trying to defeat us.”

The SEIU has found that many hospitals are turning to a negative tax in another effort to save Medicare money at the expense of their employees. Through a loophole in Social Security legislation, non-profit institutions are able to withdraw from the system after eight years, and hospitals are stampeding to the door. As of the middle of September, 460 employing 322,000 workers had filed withdrawal notices. Almost all of them are non-union.

These hospitals are biting the hand that feeds them, but they presumably figure that the hand is so big no one will notice.

“Medicare funds, which are the bulwark of our healthcare system, come entirely from Social Security contributions,” noted SEIU president Sweeney, “and withdrawals are damaging Medicare just as surely as they are undermining the solvency of the Social Security System.” His union has announced an organizing drive focusing on the issue in hospitals with no union representatives.

**Women and Children**

A year ago President Reagan was telling us that the Wall Street crowd was a bunch of nervous nellies out of touch with the vibrant pulse of the American economy. This fall these same have become stalwart visionaries, able to see prosperity and boom where others are blinded by depression-level unemployment, sales, and output. We’d like to believe that the nation’s children are among those who have faith in their future and the economy’s and have profited from the currently speculative fever on the stock market. We’d like to believe this because if they’re relying on the Federal government, they’re going to be out of luck.

The following is a summary of some current information by Rep. Toby Moffett (D-CT) in the September 15 Congressional Record:

“It seems extraordinary that in this day and age American children could be wanting, but the sad reality is that it is true. One in seven children has no regular source of health care; two out of five is not fully immunized; one out of three has never been to a dentist. Our infant mortality rate is not even among the ten lowest rates in the world. 90 out of 10,000...
Japanese children die before their first birthday, but 130 out of 10,000 American children do. Twice as many nonwhite American infants die during their first year of life as white infants.

"Clearly, there is a genuine and huge need for comprehensive children services in this nation. But the Administration has determined that the federal government should end its partnership with state and private sources in providing these services, services with proven records of effectiveness. In many cases, the federal support is modest and may appear on paper to be an insignificant amount. But to the local service provider, those modest funds are essential. The partnership is essential. The responsibility is shared.

"And what are these programs facing budget cuts or extinction? They are, by and large, exemplary, effective, and cost effective initiatives which should be expanded rather than curtailed. The supplemental food program known as WIC for nutritionally at-risk pregnant women and their children works—WIC mothers have one-third the low-birth weight babies as do similar non-WIC mothers. The Title I education program for disadvantaged children works...."

Rep. Moffett has lost his race for the Senate and his grammar could stand improvement, but his message here could not be more cogent.

Mail Supremacy

The impending doctor glut may have the AMA worried, but Centaur & Company of Washington, D.C. has seized this opportunity to market a new product which it claims will offer an edge in the growing competition for patients.

After quoting a Wall Street Journal report that "more and more doctors are finding that they must become savvy businessmen if they want to get more patients—or keep the ones they have," Centaur says, "We're just asking you to think seriously about what you probably already know—that competition for patients has been rising as the number of practicing physicians rises every year... A study for the Department of Health and Human Services predicts a surplus of about 70,000 doctors by 1990."

Centaur isn't about to suggest going out to treat the medically underserved or anything so unprofessional as offering lower fees than the competition. No. For a modest fee, it offers a leg up entitled, "Medical Tips and Trends: A Quarterly Newsletter for My Patients" with the doctor's name next to a bright red apple (for keeping the doctor away, no doubt). The illustrated pages are filled with helpful hints and tidbits on health and medicine appropriate to the season and the doctor's specialty, without intrusion of Centaur's name, copyright, or credit line—or a union bug.

According to the company's Carl H. Wurzer, "It's personal, friendly, low-key, and helpful to patients. It demonstrates your continuous interest in your patient's welfare, not only at a time of their medical need for consultation... It enhances your patients' image of you. It does not tie up valuable office hours. And it stays within the confines of good ethics."

It's easy to imagine that newsletters are only the beginning. As the competition gets keener it should bring summer surgery sales, two-for-one herniographies, redeemable coupons for x-rays, and cash rebates on CAT scans. This is one field where Yankee ingenuity should stay way ahead of the Japanese.

Hal Strelnick
(Hal Strelnick is a member of the Health/PAC Board and a doctor teaching at Montefiore Hospital in the Bronx.)

We Didn't Make This Up Dept.

CHAN, newsletter of the Consumer Health Action Network, reports that in a recent speech entitled "Hospital Industry Responses to Shortfalls in Funding for Low-Income Care," the American Hospital Association's Director of Ambulatory Care Programs offered detailed advice on discouraging "particular categories of customers."

This "selective demarketing," Linda Burns explained, "occurs when you wish to reduce demand from certain segments of the market... relatively unprofitable in themselves, or in terms of their income on other valued segments of the market."

Aware that if practiced tactlessly selective demarketing could expose the hospital to charges of racism, kicking the poor in the teeth, and similar canards, Ms. Burns hastened to add that "Sellers may not be free to refuse sales outright, whether as a matter of law or of public opinion, so they search for other means to discourage demand from unwanted customers."

She went on to spell out just what those other means might be. Separate waiting rooms for non-paying patients with few seats, poor lighting, few signs, and no food or drinks often..."
In January, 1982, Bangladesh's ten-year-old People's Health Center sent severe tremors through the international ethical drug industry by initiating its own manufacture of pharmaceuticals that could be marketed locally for 30-50 percent less than multinationals were charging for the same items. Then in May the government dramatically ordered 1,742 drugs off the market, 237 "dangerous" ones immediately and the remainder within six months.

When announcing the ban, health minister Shamsul Hug charged that "the incomplete transfer of technology, and the restrictive business practices of purchasing raw materials at inflated prices from tied sources" were detrimental to his country's economy.

At the time, multinationals controlled 75 percent of the Bangladeshi market, but the new policy outlined by the minister will allow them to sell only drugs manufactured locally and not competitive with domestic products—this will prevent below-market pricing designed to drive out small firms, a tactic multinationals have been accused of in the past.

According to SCETB, the pharmaceutical industry newsletter, U.S. Ambassador Jane Coon was quickly instructed to call on Bangladesh head of state Lt. General Hussin Mohammed Ershad as well as the health minister to petition for a delay in implementation of the new policy. The State Department followed up with a statement that the Bangladesh regulations "would affect the profit concerns" of U.S. pharmaceutical manufacturers—not an observation to be taken lightly coming from the Reagan Administration.

So far the Bangladeshis have stood by their new policy. "There is no question of it being withdrawn," affirmed Abigur Rachman, an economic attaché at the embassy in Washington. However, a poor country which relies on large infusions of foreign aid is particularly vulnerable to pressure, and the U.S. government may be willing to apply it, heavily.

Although this particular market provides a very small proportion of multinational pharmaceutical profits, allowing such a precedent could accelerate an ominous international trend. In July, 1981, Zimbabwe's Minister of Health, Dr. S.M. Ushewokinze, banned the contraceptive Depo-Provera, declaring that it "may at this very moment be posing a serious threat to the health of our women and children." At the time 180,000 Zimbabwean women were receiving Depo injections every month even though it is suspected to cause cancer and birth defects and has never been approved for use in the U.S. Nevertheless, the government's action provoked the resignation of the white director of the country's private Family Planning Association, which had been spending $1 million annually on the drug. Like other proponents, he apparently believed that uneducated women can't be trusted to remember daily contraceptives.

The response was more positive in neighboring Kenya, where Zimbabwe's ban created headlines. Depo-Provera had already been restricted to use by older women with more than four children, but Dr. Karuga Koinage,
the Director of Health Services, may follow Zimbabwe's lead.

Last April Britain called a halt to use of Depo over an extended period. In a letter to Upjohn, the manufacturer, Minister of Health Kenneth Clarke wrote that "the risk of using Depo-Provera [on a long-term basis] outweighs the benefit."

In June, the Netherlands took a long step down the Bangladesh route. A joint statement by the ministers of economic affairs and health announcing a freeze on prices of pharmaceuticals—60 percent of them imported—declared that "The drug price level has gotten so high and has had such a large impact on health care that it is of socio-economic importance to control prices. The import price is not the result of free market determinations but rather is fixed by the pricing policies of the companies."

The Reagan Administration is not pleased by these restrictions on free enterprise. "It's wrong to approach every producer, every job creator in this country as though there was something illegal about it, as though they were trying to cut corners in order to up the profits against the general welfare of the people." Vice President George Bush told the Federation of Pharmaceutical Manufacturers convention last June. As a former director of Eli Lilly, the nation's seventh largest drug manufacturer, and owner of 145,000 shares of its stock (now in a blind trust), he is certainly familiar with the problem, and his promise to fight the "bureaucratic despotism of regulation" strangling business was not just rhetoric.

One indication of the Administration's strong commitment came in a proposal Secretary of Commerce Malcolm Baldrige and then Secretary of State Alexander Haig jointly submitted to the President for two basic changes in current U.S. export policy:

- Elimination of requirements for notifying foreign governments of shipments of banned or restricted pesticides and toxic chemicals and identification of the company that makes them.
- Removal of the ban, in effect since 1938, on exporting drugs lacking FDA approval for domestic use.

Instead, the U.S. government would merely inform foreign governments of American regulations regarding hazardous substances and provide annual reports with lists of banned, restricted, unapproved, or "export only" products—without their sources.

Even within the Administration these proposals are creating an uproar. The ardently pro-business Environmental Protection Agency is among those objecting.

Despite loopholes, the current law has enabled the South Korean government to reject a shipment of PCB-contaminated animal fats, the Greeks to prevent importation of an unapproved pesticide, and the Canadians to refuse children's furniture coated with lead-based paint. It has also persuaded corporations to voluntarily destroy products taken off the U.S. market rather than turn them into cash overseas—among them Procter & Gamble's Rely Tampons and the Rohm & Haas pesticide TOK.

Shrewder U.S. policymakers might be concerned that elimination of American safeguards could spur the movement for tighter international controls. The UN General Assembly has already asked exporting nations to consult with importers on controlling banned products. The Organization of Economic Cooperation and Development (OECD), consulting body of the 24 major capitalist industrialized nations, has endorsed specific notification of these exports.

Even more threatening to the freewheeling pharmaceutical industry is a move underway in the World Health Assembly, governing body of the World Health Organization, to develop a marketing code for drugs similar to the one for infant formula. The willingness of the Reagan Administration to cast its lonely and much-criticized vote against the infant formula code can be explained by fears of creating just such a precedent.

The U.S. government is "irrevocably opposed" to the proposed WHO marketing code according to Dr. John Bryant, director of the Office of International Health of the Department of Health and Human Services. So is the Pharmaceutical Manufacturers Association. Its president Lewis Engman has protested that, "The ultimate concern of at least some of the people behind the campaign for a WHO pharmaceutical marketing code is not the health of the Third World consumers... The code movement has as its real goal the redistribution of wealth worldwide and the seizure, by political force if necessary, of economic power by those with no respect for the profit incentive and the rights of private property on which our society is based."

Some proponents of a code would find this charge laughable; others might think Mr. Engman has a fine vision, eloquently expressed.
In August, 1980, a number of construction workers in the Sydney inner suburb of Glebe started coughing after dust from asbestos panels began billowing throughout the site. Though persons installing the panels had been given respirators, they were the wrong ones for the job. Because the work was outdoors, management argued that other workers did not require any protection as the airflow would dilute the fiber concentration.

But workers, upset over the contradicting presence of their own hacks and wheezes, called in their unions, which in turn called in the Lidcombe Workers Health Centre to inspect the site and discuss the associated risks. A list of demands was drawn up and unanimously ratified, and then enforced by a six week ban on all on-site asbestos work.

Management eventually ceded to several key conditions, including use of asbestos substitutes in certain areas, industrial vacuums to reduce the level of dust and properly dispose of it, proper respirators and protective gear for the installers, and installation only after all non-essential labourers had vacated the site.

The Lidcombe Centre is the largest of several Australian collectives enmeshed in the fight to rid the workplace of the noxious toxins and unsafe equipment which contaminate it. Not only have they notched several victories and survived years of threadbare existence, their structure is an elegant model of political theory in day to day practice, a small reminder that means and ends are really one and the same.

The Centre is housed in a pair of unassuming, adjacent storefronts in Lidcombe, a working class suburb near the hub of Sydney’s westward sprawl. One half is occupied by doctors’ surgeries (examining rooms), a waiting room, and a well-stocked wall of pamphlets; the second half is a surprisingly commodious library/resource center.

“It was a conscious decision to locate where we are,” I was told when I visited the Centre on an Australian junket last August. “There was talk when we first formed the Centre back in 1977 to put it downtown where we would have higher visibility,” Robyn Booth, one of the collective’s dozen or so members, went on, “but that’s not where most workers work and certainly not where they live.” The last point is an important one. What renders the Lidcombe Centre fairly unique amongst similar Australian groups and the myriad COSH organizations in North America is its functioning clinic staffed by two full-time physicians who are collective members and draw the same low wage—$5 an hour—as non-medical staff. Augmented by sessional specialists, the clinic is able to provide a worker-oriented medical practice catering not only to individuals and their occupational health problems, but to the health needs of their families as well. That the two are often the same, with many industrial hazards coming home on the worker’s clothes or in the shopping basket masquerading as consumer products, is well understood by the staff—a rare awareness as far as general medical practice is concerned.

The clinic is not without its liabilities, however, and “the collective is forever debating whether or not it’s worth maintaining,” Robyn admitted. “Even though we can bill private insurance schemes or the government Medibank system—if the person is poor or old enough to qualify for it—the clinic

Michael Fairfax is a freelance writer and health activist living in Vancouver, B.C.
loses money.” There is collective consensus, nonetheless, that the clinic furnishes a much needed service and, perhaps more importantly, draws people into the Centre, forming the nexus between palliating immediate health problems and building broader political activities to reduce the incidence of occupational trauma and disease.

The Lidcombe Centre, in fact, and in its own words, functions primarily as an “independent non-profit research and information centre,” whose principal objective is to provide as comprehensive a service as possible so that workers can protect themselves from hazards before illness arises. While the clinic, important though it may be, remains small in relation to need, the Centre’s informational and resource services are comprehensive, up-to-date and well-packaged. The library is as good as any I’ve seen, with one entire wall devoted to U.S. National Institute for Occupational Safety and Health publications (“Not bad,” Robyn noted, “and best of all—free.”); several file cabinets are stuffed with journal reprints. Storing information and making it useful are not necessarily the same, and much of the Centre’s energy goes into the production of its many publications. Topical issues, recurrent insults, new hazards alerts, and international news are summarized in a quarterly magazine; specific problems, ranging from asbestos to brucellosis to tenosynovitis, are covered in well-illustrated, simply-written pamphlets. Emphasis is also placed on successful job actions and reiterating basic workers’ rights, important balances to the often awesome outpourings of seemingly hydra-headed work hazards. Pragmatic articles guide workers through such gritty topics as the Australian compensation maze (“$4550 lump sum for a lost thumb and up to 26 weeks of benefits payments, but you can always try suing the boss for negligence”) or workplace investigations (“the crucial things are knowledge and organization”), while the necessity of discussing problems with fellow workers, family and the union is assiduously stressed.

The task of providing such information to the Centre’s constituency has not been an easy one, given the cultural diversity of the Sydney labor force. Non English-speaking workers (referred to as “migrants”—“immigrants” and “ethnics” having become slurs, a testament to the linguistic elasticity of prejudice) face special problems in Australia, as they do in most corners of the world, summed up as a greater vulnerability to exploitation. In an effort to redress this, many Centre publications are available in Spanish, Arabic, Turkish, Greek, Italian, Serbo-Croat and Vietnamese in addition to English, and the Centre collective includes members fluent in Spanish, Greek, Arabic and Turkish.

The independence claimed by the Centre is more than euphemistic. Their funding is both slight and diverse (the trade-off being “abysmal remuneration”), with funds coming from medical fees and publication sales as well as government grants and union donations—leaving the staff reasonably unencumbered by the policies and politics of state or labor bureaucracies. “The Centre basically does what the government occupational health division should be doing but isn’t,” said Robyn, “which means that some of the time we end up taking opposite stands and refuting what they say as unscientific or wrong. Not a way to garner support.”

The relationship with organized labor, in contrast, appears to be solid and co-operative. Requests for information come from individual workers and trade unions alike, and all Centre-produced documents are careful to stress the union as the front line for both information and action. Centre staff members are invited regularly to conduct training programs for shop stewards and union delegates, and also offer an on-site inspection service—measuring gases, fumes, dust, noise levels, etc.—forwarding detailed reports to both the union and the workers involved for their discussion and decision.

The Lidcombe Centre, in other words, does not lead the movement for a safe workplace so much as straddle the chasm between workers’ concern over occupational hazards and the confusing glut of technical data usually inaccessible to all but a handful of highly trained academics.

Recently, for example, it conducted a survey on the incidence of tenosynovitis, an inflammation of the tendon sheaths primarily affecting process workers (e.g. electronics assembly), cleaners, and clerk/typists. The study was not an academic exercise, but a response to the hundreds of workers (mostly women) suffering from “this crippling new industrial epidemic,” as one Lidcombe physician described it. While Australian unions have led internationally in recognition of the problem (including strike action two years ago when afflicted women workers were threatened...
with dismissal rather than compensation), industry has ignored it, choosing to distribute analgesics to complaining workers instead. (Australia has a very high rate of analgesic-induced kidney disease.) Government occupational health inspectors have been hesitant to admit to the problem, in one case challenging the Centre’s evidence of over 250 tenosynovitis patients because “they’re only workers” whose testimony was “scientifically unreliable.” The Lidcombe Centre’s study has been a thorny refutation of such anti-industry biases, and underscores the need, acknowledged by all occupational health activists, for workers, their unions, and supporters to generate their own research and control their own information about potential hazards.

Like the other Workers Health Centres, Lidcombe attempts to link diverse issues together, more or less emphasizing the theme of “one struggle, many fronts.” Thus the tenosynovitis/repetition work problem is discussed as an occupational health concern related to the sexist and racist employment practices that determine who is hired to do such work. The stress of repetition work for women is exacerbated further by “the second job at home”; while Centre materials do not thrust a “correct line” upon their readers, they are not silent on sexual and ethnic, as well as class, inequities which affect personal health.

This connection with other issues has become especially important in environmental politics. Environmentalists and workers have often ended up on opposite sides of an issue, one decrying the spoilage of the earth while ignoring the plight of workers, the other trying desperately to maintain employment but at the expense of environmental health. Nuclear technology is a case in point, and there is no more chilling a sign of truncated politics than hardhats demonstrating for more reactors because they produce more jobs.

The Australian anti-nuclear movement is growing rapidly (some 40,000 people attended a rally in Melbourne last spring) and the Workers Health Centres are integrated into it insofar as they produce information and conduct workshops on the hazards of radiation. Their focus remains the health of workers but, as one of their recent newsletters stated, “the only real protection for workers is no uranium mining or processing for nuclear weapons or nuclear power.”

The Australian labor movement has responded affirmatively to the anti-nuke movement, garnering kudos from environmentalists for their role “in building community attention on the uranium issue and the serious problems associated with the industry.” In some cases workers have refused to handle “yellowcake” — Australia has recently begun to exploit its massive reserves of uranium—and most unions and their central organs have passed resolutions supporting a ban on uranium mining and nuclear reactors. The federal Liberals, however, have imposed heavy political and economic penalties on workers and unions involved in the boycott, forcing several to reverse their official stance. Environmentalists and occupational health activists have both worked to ensure that this does not drive a wedge between the two movements, discussing the political context of their differing tactics.

All told there are some eight different workers health groups in the three populous eastern states of Australia, including one devoted exclusively to occupational problems faced by women; efforts continue to establish others in the remaining three states and two territories. (This figure is exclusive of the trade union movement which, until recently, has not paid much attention to occupational health matters. In the past couple of years, however, the large and powerful Amalgamated Metal Workers and Shipwrights has hired a full-time safety officer and the Australian Council of Trade Unions now has two staff members drafting model guidelines and producing monthly newsletters.) Information sharing, even personnel exchange, are the rule among these groups, though their particular foci are determined by local issues — as one Australian environmentalist pamphlet put it, “Think globally, act locally.” The Queensland Centre, for instance, places heavy emphasis on pesticide safety. The state’s largely tropical climate permits a year-round agricultural industry and the ubiquity of insects has led to massive chemical use on construction sites.

But if different Centres at times have disparate struggles, industrial toxins and dangerous work practices tend to be universal, as does the indolence of industry and the state in correcting them. Principles of effective worker opposition also differ little between states, countries or even continents, and the following list (taken from a Queensland Centre newsletter) is a fair statement of such ideals:

- All workers have the right to work that is not dangerous to their health.
• Information about occupational health is not the private property of governments or employers. It is the property of all workers.
• Prevention of hazards is the only means to good health in the workplace.
• Workers and unions have a crucial role to play in identifying hazards, and acting to correct them through industrial action. Legislation with teeth must be enacted to support this activity. Define workers’ rights and establish adequate standards. However its effectiveness is always as support, NOT as a substitute, for workers’ action.
• The Workers Health Centre exists to support and strengthen the struggle for non-hazardous workplaces by collaborating with workers and unions to identify, document and eliminate work hazards.

Each one of these principles has been buttressed by years of contrary experience. For example, Australian workers in most, if not all, states do not have the legal right to refuse hazardous work without employer reprisal. There is a long history of information suppression by industry. The Australian asbestos company James Hardie, for one, employed Aboriginal workers in one of its mines at pittance wages and exposed them to 140 times the British dust standard. It denied the existence of any health risks and to this day refuses to provide fair compensation for the resultant deaths and injuries. Despite some 150 national and state occupational health laws, most job hazards are controlled by management self-regulation, “codes of practice” with no legal liability — an evocative comment on the limits of legislative solutions. Only 3 chemicals on the NIOSH list of industrial carcinogens are regulated in the state of New South Wales, none in the state of Victoria. Even in New South Wales the regulations apply to less than one-third of the workforce.

A situation where “legislation to protect workers’ health is far less adequate than that protecting the environment,” as a member of the Victoria Workers’ Health Action Group described it, merits further comment, especially when it describes a country where the labor force is heavily unionized (55 percent) and managed to put a federal Labour government in office from 1972 to 1975. While the latter did succeed in introducing several health reforms, notably the Medibank universal insurance scheme (since gutted by the right-wing Liberal government) and a network of community health centres, it was hamstrung on occupa-

Health/PAC Bulletin
While the Queensland Centre's first four principles remain little more than idealistic rhetoric, fulfilling their last, collaborating with workers and unions, has become a source of justifiable pride. Instead of bolting for the political leadership as too many well-meaning, socialist-minded intellectuals are wont to do, a bunch of "ratbags" (an ockerism, or Aussie lingo, for anyone resembling a left-wing-pinko-commie-faggot-dyke-hippy-layabout and student) has put together a service immediately useful to, and used by, a class less privileged than themselves.

Following the example of feminist health collectives, these groups also attempt to function according to the ideals they espouse, so that change is enacted as important as, if not synonymous with, the change for which they work. As the Lidcombe Centre's pamphlets state, "We work as a collective, which means that all major decisions about how the Centre is run are made at a weekly meeting attended by all members. We have no official positions within the collective, and all members have an equal voice in the decision-making." That the Lidcombe Centre has survived for five years without apparently compromising those principles, that others have grown in recent years and in spite of hardening times, and that they have contributed to some real victories along the way is something from which health activists (or progressives of almost any stripe) can take encouragement—and who doesn't need some of that these days?

Summing it up with simple clarity, Ben Bartlett and the Lidcombe collective put it thus: "Changes in occupational health will occur through the action of workers themselves. Some form of worker organisation is essential. The value of our work can be gauged, to a large extent, by the degree to which we assist this process."

In the hope of furthering information-sharing and support, below are names, addresses and regular publications (when known) of Australian occupational health groups. Prices are in Australian dollars.

Lidcombe Workers Health Centre
27 John Street
Lidcombe, New South Wales, 2141
—publishes magazine WORK HAZARDS ($5 for 1 year, individuals, rank and file groups; $7.50 for unions, community groups, schools; $15 for tertiary education institutions)
—also publishes regular pamphlets and a good booklet on "How to Find Hazards Before They Find You"

Occupational Safety and Health Action Group (OSHAG)
c/o AMSWU Health and Safety Officer
136 Chalmers Street
Surry Hills, New South Wales, 2010
—works closely with the Lidcombe Centre

Workers Research Centre
Occupational Health Group
Ironworkers Building, 325 Crown Street
Wollongong, New South Wales, 2500

Trade Union Research Centre
c/o Trades Hall, Union Street
Newcastle, New South Wales, 2300

Brisbane Workers Health Centre
5th Floor, Trades Hall
Edward Street,
Brisbane, Queensland, 4000
—publishes bimonthly bulletin HAZARDS ($5 for 1 year, individuals and rank and file groups; $10 for organizations)

Working Women's Centre
423 Little Collins Street
Melbourne, Victoria, 3000

Workers Health Resource Centre
Room 18, Tredled Hall
Carlton South, Victoria, 3083

Worker Health Action Group
P.O. Box 271
Carlton South, Victoria, 3053
—publishes a regular bulletin, title and cost not known

ACTU-VTHC (Australian Council of Trade Unions/Victorian Trades Hall Council)
Trades Hall, P.O. Box 93
Carlton South, Victoria, 3053
—publishes a regular HEALTH AND SAFETY BULLETIN (no price indicated)
A Note on the Photographs

These pictures were taken by Frank B. Gilbreth, the noted scientific management expert whose family life was immortalized in the Hollywood movie Cheaper by the Dozen. Together with Drs. Ernest Codman and Robert Dickinson he worked during the years 1913-18 to apply the techniques he had developed in industry to hospitals.

In these photographs the doctors (numbered) and nurses (lettered) were in front of a special grid which facilitated study of each micromotion.

According to Charles D. Wrege of Rutgers University, "Many ideas now being advocated, such as the problem-oriented hospital record, Professional Service Review Organizations (PSRO's), and hospital manpower surveys, can be traced to the pioneer ideas of Codman, Dickinson, and Gilbreth."
The class of 100 graduate students was listening to the lecture like any other, some students attentive, some not, all preoccupied with taking notes rather than participating. Suddenly it became a class of 100 aroused and agitated nurses. The stimulus was a passing reference to temporary agencies.

"They're the worst," exclaimed one student.

"They come in, don't know anything about the hospital and ask a million questions about where everything is," complained another. "I spend half my time orienting them to the floor. They leave after one shift, never come back, and I have to start all over again the next evening with another 'temp.'"

"Some of them haven't been in a hospital in years and probably never in an ICU [Intensive Care Unit]. The other night there were four of them and me in our CCU [Cardiac Care Unit]. I wound up doing all the treatments, all the meds, and half the feedings. The temps took the vital signs but I think I even charted them because the temps couldn't figure out our system."

"There were two of them and two of us staff nurses in the surgical ICU the other evening with eight very sick patients. Three fresh postops that day. And it seemed as if every family had decided to visit right then and, of course, they all had questions. So there's Susan and me counseling families, monitoring machines, posting doctors' orders—because temps aren't allowed to do that—directing traffic, answering questions, drawing blood gases, regulating IV's...."

Patricia Moccia teaches at the Hunter-Bellevue School of Nursing and is a member of the Health/PAC Board.

"The real kicker," called out one student, "is they get more money per shift than I do."

"They don't care about anything like charting, lab reports, or requisitions because they don't have to come back," said another angrily, "and when the docs or the labs are looking for some answers we have to do it all."

"They work when they want while the rest of us have to put up with lousy, lousy rotations."

"They're more trouble than they're worth."

Each complaint elicited vehement nods of assent and still more expressions of anger, frustration, and resentment. The class time had never passed so quickly.

Seeking another point of view, I asked if any students in the class had worked as temps. No hands went up but shifting bodies and averted eyes led me to suggest a secret poll. When the papers were all tallied, we found more than half the class had written "yes." The nurses had been talking about themselves.

Clearly, nurses often find temp nursing attractive personally, but in their role as staff nurses they find its impact on patient care and collegial relationships troubling. In many parts of the country the explosive growth of temp nursing in the last few years has compelled nurses to raise questions about the structure of the health system as a whole:

Can hospital work be organized more humanely?

Is quality care possible within the present organizational structure?

Which conditions foster or obstruct a collective consciousness?

Hospitals have always used temp or per diem nurses to "fill in" during vacation times, high census periods, and unusually large sick calls. The current phenomenon is quantitatively and qualitatively new.
With some hospitals facing staff vacancy rates as high as 15 percent (see Figure 1) and turnover rates of up to 67 percent, in an increasing number temps constitute the majority in both general and specialty units. In some cases they constitute the entire unit staff. There are hospitals which use temp nurses to meet as much as 80 percent of their general staffing requirements.2 A few are contracting with outside agencies for their entire nursing staff (see Figure 2). Whether these rates are indicative of a real nursing shortage or of maldistribution of available skills and services is a subject for heated debate (see box).

Historically, hospitals satisfied their more modest extra staffing needs through their own registries and/or “float pools”—nurses not assigned to a specific unit. This allowed the institution to maintain some measure of professional control, and its supervisory staff some measure of control over scheduling. Now it is the individual temp nurse who decides when to work, what hospital to work in, which unit to work on, and which agency to work through.

Perhaps most significant of all, the context of temp nursing has changed. Nurses have long been dissatisfied with their fragmented and alienating working experiences in hospitals. Now they are expressing their views in increasingly militant collective actions that place the blame for inadequate care on rigid, profit-oriented hierarchies instead of allowing it to fall on individual nurses who “are never around when you need them.”

This rank and file movement prodded the American Nurses Association to set the economic and general welfare of nurses as their first priority for the 1981-1982 fiscal years. Groups such as Nurses Network and trade unions in the field—most prominently District 1199 of the Retail, Wholesale, and Department Store Union (RWDSU) and the Service Employees International Union (SEIU)—were several years ahead in recognizing the close to intolerable working conditions of most nurses.

In this situation of increasingly assertive nursing activity, temp nursing becomes more than a way of filling staffing gaps. In addition to dramatic, hard-nosed use of temps as scab labor—often flown in from other states during strikes (see box)—their regular employment erodes the potential for collective consciousness and solidarity among nurses by fragmenting and de-skilling the staff of an institution. Nurses who see each other a single day on which some are hanging all the IV’s and others are doing pre-op teaching are not easily united. Since nursing is the largest single segment in the health labor force and the one which relates most closely to all the others, this inevitably impedes the development of a unified labor force.

“Ⅰ’ve had it with the hospitals. The only way to go is with agencies.”

“The agencies are just as bad as hospitals. They throw their nurses around like wet spaghetti.”

When a discussion of temp nursing begins with questions such as, “How will the shifts get covered?” “What about patient care?” and blame for inadequate care on rigid, profit-oriented hierarchies instead of allowing it to fall on individual nurses who “are never around when you need them.”
"What about loyalty to the institution?", nurses usually don’t come off very well, since the assumption is that these are areas under their control in the first place. A staff nurse in a medical ICU of a 600-bed community hospital who reports that "I am the only regularly scheduled person for any of the three shifts in my unit," doesn’t see it that way.

Flying Nurses

Flying Nurses is a national temporary nurses agency, based in Texas that specialises in flying nurses from around the country into institutions that need nurses and can’t recruit them locally; at high pay for the nurses, and a tidy profit for the agency.

This spring, in San Jose, California, four hospitals found themselves with a sudden acute shortage of nurses, and unable to recruit locally. Their nurses, members of the California Nurses Association, were on strike. By furnishing replacements for the striking nurses, Flying Nurses broke the CNA’s strike at three hospitals, and weakened it at the fourth. The American Nurses Association has called for a boycott of Flying Nurses, and NURSES CAUCUS NEWSLETTER urges its readers to protest any use of Flying Nurses at their institutions, and to persuade any Flying Nurses they know to find another agency.

(Reprinted from Nurses Caucus Newsletter, published bimonthly by the Nurses Caucus of the Democratic Socialists of America.)

From his or her point of view the key question is, "How do temp nurse agencies alter the relations between them, the administration, the patients, and the rest of the staff?"

"I can’t afford to work full-time for a hospital. Salaries and benefits are terrible. Staff nurses are busting a gut for as little as 5.25 an hour. I get nowhere trying to change things. So I went to work for an agency and found that it was in effect my personal bargaining agent."

(Nursing ’80 survey response)

"It’s not just monetary. It’s being able to do nursing and to have some control over your own practice and patients." (Patricia Jones, ANA’s government relations director).

The tone of administrative reaction to the grievances of nurses, whether across negotiating tables, in professional journals, or on the cafeteria lines, is disturbingly reminiscent of parents dealing with rebellious adolescents. Figuratively or literally wringing their hands, shaking their heads, and ultimately stomping their feet, hospital management and its representatives are beside themselves trying to figure out how to keep "the girls" in line. Just as frustrated parents seize on curfews, they grasp at schedules, asking "Will we get shifts covered with temps?"

The answer is "They will."

The initial findings of a national study show there are no significant differences in shift coverage between hospitals that do and do not use agencies for a large percentage of their nurses (see Figure three). On closer examination, analysts have figured out that the real question is "Who will have control over the shifts?"

Obviously, nurses who sell services through an agency have more control over when they work. This issue of control—over working conditions, time, and practice, is a recurring theme in the more basic conflict between nurses and the hospital administration—which expresses it very differently.

When satisfied that the shifts will be covered, the typical administrator then asks, "But what makes these nurses so unhappy now?"

Management’s ready answers are stabs at the women’s movement and overeducation (the nurses’, not theirs). The assumption is that some time in the past nurses happily performed their hospital duties, enjoying the autonomy and dignity they merited as skilled professionals.

Figure Three

WHO WORKS WHEN

"Data from a preliminary survey of 200 staff and temporary service nurses indicated that there were no significant differences in the distribution of shifts worked by the sample of agency and staff nurses."

<table>
<thead>
<tr>
<th>Type of Nurse</th>
<th>Temporary</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift Worked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td>31%</td>
<td>25%</td>
</tr>
<tr>
<td>Evenings</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Nights</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Mixture of Shifts</td>
<td>25%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Nurses and Registries:

In the uncertainty and disorder of the nursing marketplace, various types of registries have arisen in attempts to match nursing supply to patient and hospital demand. However these registries have always been problematic agencies and sources of discontent, responsive more to prevailing market shifts than patients’ or nurses’ needs.

Prior to the introduction of training schools for nurses in hospitals in 1873 both the relatively few hospitals in existence and patients who needed private duty nurses in their homes found nursing personnel primarily through informal channels. Families relied on physician and druggist lists, ads placed by nurses in newspapers and city directories, or word of mouth. In those pre-telephone days it was not uncommon for a distraught relative of an ill person to ride around from one nurse’s address to another in search of someone to hire.

Hospitals met their needs for nursing personnel through advertising, informal staff recommendations, or, most often, by impressing the most ambulatory patient or some other hospital worker. One hospital matron, for example, placed this ad in a newspaper in 1874: “Wanted, a nurse for the Boston Lying-in Hospital, experience not required.” When she couldn’t find someone to take the job (she reported the applicants weren’t prepossessing enough), she had one of the recuperating patients become the hospital laundress and promoted the laundress to nurse.

SUSAN REVERBY is an historian of nursing currently teaching Women’s Studies at Wellesley College and a former Health/PAC staff member.

Registries for nurses began to develop in the last quarter of the 19th century, primarily to supply private duty nurses to patients in their homes. Some provided “specials” for fee-paying patients in the hospitals, but after they introduced in-house nurse training schools, hospitals relied on students supplemented by untrained attendants for their regular needs. If a shortage arose, the nursing school superintendent (who also often served as director of the nursing service) would call up a student on the waiting list or shift students from one floor to another—regardless of their experience or educational needs.

The first Directory for Nurses, organized by the Boston Medical Library in 1879, supplied the names of 4550 nurses to the New England region over its 35 year history. This listing saved physicians the trouble of finding nurses for their patients, gave patients a central place to locate nurses, and provided the Library’s most important source of income.

Signing up at a registry soon became the graduating nurse’s most important ritual, but he or she frequently was dissatisfied with the results. The “best” cases, they charged, were often handed out to favorites, nurses were more likely to be sent out if they were willing to accept less than the customary rate, and the registries sometimes failed to find work for them at all. Yet as one nurse lamented in 1895, “most graduates do not feel that they are fairly treated by the directory but are afraid to complain for fear that it will be visited upon them . . . .”

The discontent was so frequently voiced at nursing meetings that the American Nurses Association leadership urged nurses to work
only for “official” nurse-controlled directories. Nurses who followed this advice discovered that joining an “official” registry was not a guarantee of work either. At the turn of the century the private duty market was becoming increasingly crowded and hospital staffing remained the province of the untrained attendant and student nurse. “It is not so much a share in the government of directories,” wrote one rank and file nurse voicing a sentiment common in 1894, “as a share in the work given out by them that is asked by the majority of nurses.”

By the early 1900’s numerous registries could be found in the major cities. Some hospital and nursing school alumnae registries supplied only their own graduates as “specials” to particular hospitals, many of which still used the registries only to shore up their student service. “Official” nursing registries gave out work to graduate nurses only. Commercially-run agencies supplied both graduate nurses and untrained practicals. Nursing discontent with the system continued to run high. In a turbulent discussion at the 1924 ANA convention, nurses admitted that they found the many commercial agencies which allowed experienced graduate nurses to charge higher rates more attractive than the “official” nursing registries, which maintained uniform rates. Thus the registries at best functioned only as nursing employment agencies or hiring halls for hospital “specials,” rather than as either community services or professional organizations.

During the early Depression years the ANA’s Director at Headquarters, Janet Geister, attempted to reorganize the nurse-controlled registries. Geister hoped to make them more community-service oriented, and encouraged “need-based” planning to match community nursing needs to nursing supply. She also hoped these registries would become the center of continuing education for the more isolated private duty workers.

These efforts were thwarted by the nursing leadership, which considered them a threat to their goals of hospital staff nursing by graduates and expansion of public health nursing services. By midcentury the registries remained nothing more than commercially-oriented employment agencies, helping to stave off disasters on hospital floors or provide the dwindling number of private duty nurses and attendants caring for patients in their homes. They remained outside efforts to improve conditions for nurses by either professional or more trade unionist means, and remained unresponsive to real nursing needs, both inside and outside hospital walls.

NOTE ON SOURCES:
In truth, nurses were never happy staffing hospitals (see box). A review of professional journals of the 1930's quickly reveals that only the weapons of professional sanction and monopolistic control of health care enabled the institutional hierarchy to exhort, cajole, and eventually force nurses into ceding their position as independent practitioners contracting services to individual patients and physicians and entering institutions as dependent, subservient staff, a position they continue to resist to this day.

Within this history, the trend to agency, employment can be seen as a resurgence of strivings to regain at least some of that lost autonomy, which permitted nurses to focus their attention primarily on their individual patients, rather than on administration directives.

If administrators saw it this way, they would be asking themselves what it is about the hierarchy and organization of work within the hospital that has repelled the largest group within the health care workforce for over 55 years and is alienating them today with increasing intensity.

In survey after survey, nurses have provided specific answers. They say they are tired of erratic and exhausting shift rotation, inadequate staff and material resources, and a pay scale that barely rewards either clinical competence or seniority. Nurses who leave the profession entirely cite an inability to effect change either for their patients or for themselves. What they want to change is the basic conditions in the hospital.

"The nurse came in, sat down next to the patient's bed. Never said a word to him. She

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Is there a nursing shortage?

Whether or not there is really a nursing shortage, and if so the reasons for it, is a subject of considerable debate.

At the Federal level, the last three administrations have refused to recognize a shortage, although Congress has disagreed.

Some analysts suggest that there is not a shortage of nurses but a lack of nurses with "appropriate skill levels." Others argue that there are enough nurses, it's just that many are all working in non-health related fields. Still others say that while the nurses might stay in the health field, they are employed in non-hospital settings to an increasing degree.

Those that acknowledge the nursing shortage offer many reasons—an increase in the number of inpatient days; an increase in the intensity and complexity of patient conditions with a consequent increase in the demand for nursing services; and a decrease in the average length of hospital stay, which again increases the demands for nursing service.

Yet another observation has the broadest implications for nursing, women's professions, and the health labor force: there is a relationship between nurse vacancy rates in hospitals and the depressed ratio of nurses' income to those of other workers. (See Figure 2.)

Some of the statistics:

I. The American Hospital Association estimates a national shortage of 100,000 nurses.

RN Magazine reports that 90 percent of short term and 75 percent of long-term institutions have budgeted RN vacancies.

The AHA concludes that the inadequate supply of RN's has caused bed closures and disruption in service delivery.

II. The American Nurses Association reports that there are 1.4 million RN's licensed to practice in the US.

ANA reports that 70 percent of this total are employed in nursing, two thirds full-time, the rest part-time; only four percent of RN's are working in non-health jobs.

The National League for Nursing reports that the nurse unemployment rate has declined since 1976 and presently sits at 1.9 percent.

III. The National League for Nursing reports that applications to schools of nursing declined 16 percent between 1977 and 1978, and project a continuing decline that will be accelerated by the current administration's budget reallocations.

The NLN also reports that graduations are expected to decline at a rate of three percent over at least the next four years.

The U.S. Dept. of Labor projects another 240,000 unfilled new nursing jobs by 1985 beyond the current 100,000.
had a Sony Walkman on, I swear she sat there from four p.m. until 12 without moving the patient once. And he was a fresh post-op. I mean, not a ‘Cough’ or ‘Deep breath’ out of her. And you can forget about his getting turned. If his temp wasn’t 104 by midnight, it was a miracle. I called the staff nurses but they said they couldn’t do anything. She was a temp.”

—A temp nurse with the patient in the adjoining bed.

“Agency nursing is wonderful. It’s like being part of a fifth column. We can do our work right under the hospital’s nose. We can teach the patients about their illness, talk to them about their health, counsel the family. I think we can take over patient care from the inside.”

—The same temp nurse quoted above.

Theoretically, quality care is minimally ensured through licensure, professional standards, and credentialled expertise in clinical specialties. Most discussions of quality care also include the need for continuity, and this is frequently used as an argument against temp nurses.

When nurses hear the continuity argument their most common reaction is a bitter laugh. Current staffing patterns rarely place a nurse with the same patient more than two days in a row on the same shift. In a system so fragmented, disjointed, and haphazard, they would add, it would be ridiculous to expect anything else.

Enforcing even minimum professional standards in temp agency recruitment is another issue, and a very serious one. Typhoid Mary or someone whose only experience with nursing was taking care of dolls as a child could easily pass muster at many agencies. Newspaper advertisements promise “Immediate Placement,” which often means being signed up at 12 noon for a four p.m. to midnight shift.

A random review of agencies heavily used in New York City indicated that even those few which print minimal standards rarely if ever attempt to enforce them. Licenses are not asked for, references are not checked, past work places listed are not called. Clinical competence is commonly either assumed (if we give the agency the benefit of the doubt) or disregarded. Hospitals have been equally lax in screening the people sent over.

The inevitable disasters which result, with increasing frequency, have been protested by regular staff nurses who see the impact on patient care from their frontline positions. Various remedial activities have been initiated.

In the Northeast, some state nurses associations have been approached by nurses to start professionally monitored agencies and one large municipal system has begun its own agency. On the West Coast hospitals have established their own controls. In the Midwest a joint council comprised of representatives from both proprietary agencies and health care institutions has developed a code of standards.

Nevertheless, the belated and arbitrary manner in which these reforms are emerging raises serious and troubling questions about the commitment to quality care among hospital administrators, not to say proprietary temp agencies.

The inevitable disasters which result, with increasing frequency, have been protested by regular staff nurses who see the impact on patient care from their frontline positions. Various remedial activities have been initiated.

—A state nurses association flyer

“Collective bargaining is professional.”

—An American Nurse Association flyer.

The growth of agency employment has sharpened the ambiguities in the relations...
between nurses and other health providers. Historically, although nursing has found itself with different allies at different times, it has consistently been defined by others within the ideology of scientific medicine. Since this ideology is less rigorous and less grounded in reality than it pretends to be (anyone who thinks otherwise might compare, say, the arts of preventing and treating heart disease with the science of locating Halley’s Comet), nursing has often been called to task for its inability or unwillingness to establish rigid boundaries around itself as a discipline. Individuals and groups within nursing have also expended a great deal of mental energy wrestling with questions such as “Is nursing ‘part of’ medicine and do we have most in common with physicians?” “Are we professionals or semi-professionals?” and “Am I a worker or a manager?”

It is generally agreed that lack of consensus on the answers to these questions is at the root of nursing’s inability to wield the influence its history, numbers, and central position within health care appear to justify. For duration and intensity, the conflict within nursing over whether the primary peer group is or ought to be hospital workers or physicians, nurses, and other healers rivals the Cold War. The particular flash points have been over issues such as entry into practice requirements (B.S., A.D., or diploma), relevant educational experiences (theory vs. practice), appropriate collective bargaining agents (state nurses associations or trade unions), acceptable trade-offs for funding (e.g. Nurse Practitioner programs or any others that require physician preceptors), titles (independent nurse practitioner, professional nurse, technical nurse, associate nurse, physician extender).

The growing number of nurses signing up for trade unions and the new willingness of many state nurses associations to engage in tough collective bargaining reflects the trend toward a nurse-as-worker perspective. Paradoxically, the same dissatisfactions which are pressing nurses in this direction are also causing many to become temps, abandoning the institutional allegiances which allow them to challenge the system’s shaky hierarchy.

Hospital administrators relying on temp nurses for a substantial proportion of their workforce have undoubtedly been aware of this. Still, it does seem strange at first glance that hospitals strapped for funds would pay temps higher daily rates than they give their staff nurses — seniority wages and benefits do not account for the difference given the de facto ceiling on nurses’ wages throughout the country. If this allows the hospitals to keep the wages of their nursing staff lower, however, it makes more budgetary sense.

It is no secret that if nurses had more power their wage demands would probably not be modest. Speaking at a plenary session of the American Nurses Association, the New York State association’s Executive Director quoted a judge who decided against a nurse in a recent “comparative worth” case because “a ruling favorable to the nurse plaintiff would have the potential of disrupting the entire economic system of the United States of America.” Dr. Welch won sustained applause when she went on to comment, “The conclusion is inevitable. Establishing the economic value of professional nursing practice will require nothing short of a social revolution.”

Most hospital administrations are unenthusiastic about social revolutions, particularly ones which could bankrupt them. Agency nursing is costly, but they may feel that preserving their institution today and reshaping it to survive in the hotly competitive years ahead requires this investment.

Aside from weakening collective identity among nurses, agency nursing can play a key
role in lowering expectations of what constitutes hospital nursing care. Patients can be told, "There is a nurse, but as a temp she can't perform that particular task; you'll have to wait for the staff nurse to make her rounds tomorrow morning." Gradually work could be segmented to such a degree that most tasks now performed by skilled and relatively well paid nurses could be allotted to low-wage workers — a category which would include most remaining nurses. Only a small, privileged elite would escape this degradation in function and position.

Patients might be unhappy with these changes, but it would be naive to believe that health care is designed to serve them. The devastating reality is that the rare patient who enjoys quality nursing care receives it in spite of a system whose own maintenance demands more and more of the nurse's attention—at the expense, literally and figuratively, of the patient.

Here lies the irony of short term benefits in a reorganization which will lead to long term disaster. For those nurses with the will and competence to provide quality care, as well as their patients, "temping" can offer much more positive benefits. As they regain their autonomy from the rigidly stratified and intricate hospital bureaucracy, nurses are freer to direct their complete attention and energies toward nursing the patient rather than "nursing the system." For the first time, they can provide care which approximates the ideal models they were taught in school. As a result, the phenomenon of "reality shock" so often observed among new nursing graduates and blamed for job dissatisfaction, turnover, and the nursing shortage may rapidly decrease.

Despite the chronic problem of poor staffing compounded by inadequate screening for credentials, most nurses are convinced that studies now underway on the comparative effectiveness of staff and temp nurses will vindicate their position that any way of delivering patient care is better than the traditional system. They feel the agencies can free them from the alienated and alienating hospital routine, allowing more time and energy for direct patient care — the interaction vitalizing the human spirit which attracted them to nursing in the first place. From the nurses' point of view, the popularity of the agencies is a testimony to the dehumanizing conditions of hospital work, a refutation of the myth that there is a special humanity in hospitals.

Unfortunately, as we have seen, the liberation of agency nursing may in actuality be a free fall into oblivion. Nursing care—the heart, both in symbol and in reality, of the health care system—is threatened with extinction. If it goes, so might any remaining evidence that the goal of the health care system is anything other than profits. The devastating immediate impact on patient care would be compounded by the more subtle long term deterioration in conditions for other health care workers and in the organization of the health care system itself.

The crucial issue over the next few years is whether nurses, together with other members of the health labor force and health consumers, will be able to resist this institutional juggernaut and establish a more caring, effective, and responsive health care system. The old system is dying. The only question is what will replace it.

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Reality Strikes Homecare

by Mary Ittmann Murrey

The workers have been on their Ohio picket line since August 16. The issue is speedup, as it was in the 1972 wildcat at the Lordstown, Ohio, GM plant. But this time the strikers are Registered Nurses of the Visiting Nurses Association of Cleveland and members of the Ohio Nurses Association. Nurses who have been taught to believe that as professionals they have control over their work.

Their work is providing health care to ill people at home. Although this would seem to give them a great deal of autonomy, the quality of the care they can give is heavily influenced by their caseload—the number and difficulty of cases or clients. Over this they have had no real control. Often they have been forced to see seven to nine patients a day. Even calculating the travel time that this would involve will indicate why they felt their patients were suffering inferior care and decided to unionize in 1980.

After six months of negotiations the VNA management bowed to an ONA strike threat in July, 1981, and signed a two-year collective bargaining agreement. This included a raise and a provision that caseload would be determined by the complexity of each case rather than remain a defined number of patients. Guidelines and criteria were to be set by a Nurse Practice Committee composed of representatives from both management and staff nurses. If a nurse and his or her supervisor determined that a caseload exceeded the established limit, management was obligated to lighten the burden. How—shifting the caseload, hiring more nurses, shutting down patient intake—was left to the VNA administration.

The nurses thought this was an important victory. Apparently, management thought it was a disastrous defeat. While the nurses had been organizing, the VNA Board of Trustees had been reorganizing. Formerly it had been primarily a group of upper class women who left day to day operations to the administrative staff and concentrated on fundraising and social events such as providing the nurses with Christmas candy. The new board members recruited were business and professional people prepared to take an active role in policy decision. And they were management tough.

Janet Price, RN, had been Executive Director of VNA for 15 years and on the staff for five before that. Often described as a “benevolent mother figure,” she considered the nurses’ decision to organize for collective bargaining a personal betrayal, but she reluctantly acceded. Within five months she was out, replaced by Gloria Pace King, an RN with an advanced degree in business, a strong management background, a reputation for being tough with labor, and a management style described by at least one supervisor as “autocratic.”

The atmosphere in the Nurse Practice Committee, which began functioning in August shortly after the contract was signed, quickly changed when King took over in December. Management representatives became disruptive and failed to show up for meetings. Then in March, 1982, to the amazement of the nurses the VNA fiscal director announced that the committee’s task appeared impossible and called for an indefinite adjournment. Voting as a bloc, management supported this position and the meeting was adjourned. With the exception of a meeting requested by

Mary Ittmann Murrey is an RN at Home Health Care, a non-profit agency very similar in function to Visiting Nurses Association, and a reader of the Health/PAC Bulletin.
the nurses to vote for a report to the director, it never reconvened.

When negotiations over salary and caseload were reopened last June, VNA management announced to a shocked ONA negotiating committee that the caseload article in the contract had to go. In a last effort to head off a strike, the nurses proposed that the existing system be replaced by a daily average caseload of 5.5 visits during each two week period. The administration said no. Its only counterproposal to date is a return to the policy of the previous two decades: no specified limit on caseload, but nurses would be permitted to take up any complaints with management.

Convinced that this offer was meaningless without any objective standard on which their grievances could be based or any assurance that these grievances would be heeded, the nurses went out on strike.

Negotiations continued, with the ONA offering to accept binding arbitration. Management refused. The nurses offered to drop their wage demands and accept the nine percent raise proposed by the VNA with no back pay for strikers. However when management made it clear that even the nine percent increase was contingent upon their agreement to drop the caseload clause the nurses stayed on the picket line. Their next proposal was to drop the caseload clause from the grievance procedure if management accepted the 5.5 average visits limit—a significant retreat since excluding caseload from grievances effectively made this ceiling unenforceable.

"Sister's not enough of a name," he whispered. "You've been more than a nurse; you've been a friend."
The ONA thought it had given back enough to satisfy management. Although nurses were often forced to see seven to nine patients a day, they say that on average they were visiting somewhere between five and six. The VNA has claimed that the average was only three to five. By the nurses' calculation, a 5.5 daily average would be only a small reduction from actual pre-strike practice. By management's calculation, it would actually be an increase, and any excess could be imposed without fear of grievance.

Yet management turned this offer down. This suggests that a different set of issues is at stake: power, authority, and control. The nurses believe that the conflict is over who runs the agency, over limited vs. unlimited caseload and control by management, over whether the VNA is a nursing association or a business venture, and over the willingness of the administration to work with unionized nurses.

The VNA has been in serious financial difficulties for several years (the current management says the problem isn't so much Federal and state cutbacks as the fiscal irresponsibility of its predecessors in maintaining a "Children-risk" program without funding). In the old days, before collective bargaining, the fiscal director responded to deficits by calling an inservice meeting and showing the nurses graphs and numbers designed to demonstrate that it was their duty to close the gap by accepting a heavier caseload.

The nurses are convinced that management wants to return to the past by breaking the union and restaffing the agency with nurses who are not so demanding. Recertification of the contract comes up next summer and a management challenge to the nursing organization would force a new election. The old public relations director has been replaced by the PR director of Ashtabula Hospital during the bitter strike there last year.

The administration's latest tactic has been to discharge all 42 nurses who are still out on strike. Although by law the VNA can't "fire" them, it can "permanently replace" them. The replacements are receiving $17.50 an hour, a very high wage for Cleveland.

The nurses' demand for a controlling voice in determining how health care will be delivered has tested the meaning of professionalism. A profession, guided by a code of ethics and standards of performance, is a self-regulating occupational group which performs unique work requiring special training. RN's are educationally prepared to meet the criteria for professionals. However within the medical system as it is structured today they are not autonomous and independent but rather employees of institutions in which they are excluded from decision-making which affects their work. The VNA's demand for unilateral control over caseload is an example of these kinds of decisions. The stark difference between the rhetoric of professionalism and the reality of the limits of nurses' control over their work is exemplified in VNA's assertion that "input is one thing, control is another."

The ideology of professionalism has for many years acted as a deterrent to nursing organization and strike action. Striking was viewed as "unprofessional," a tactic which could only improve nurses' conditions at the expense of the patient. In fact, it was not until 1966 that the American Nurses Association rescinded its "no-strike" policy established in 1950.

The use of "professionalism" to control nurses is still common. The VNA claims that it is "not professional" for nurses to demand a caseload limit. Management has openly stated that its objection to a caseload clause has nothing to do with finances, asserting that it is trying to protect "management prerogative" from nursing infringement which is not "appropriate."

The nurses have vowed to stay on their picket line until Christmas if necessary. They are out there every day, rotating shifts every two hours. They also plan to begin directing community pressure against members of the board.

Donations and offers of assistance can be sent to: ONA, P.O. Box 78, Northfield, Ohio, 44061.

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Barns & Noble Works

The American Rural Health Association is soliciting proposals for research papers and workshops for its annual Institute on the Delivery of Human Services to Rural People to be held at Lake Tahoe, Nevada, June 11-13, 1983.

Detailed procedures for submissions are available from Dr. Raymond Coward, Center for Rural Studies, The University of Vermont, Burlington, VT 04501. The deadline for submissions is January 1.

Singing Union

If you’re looking for something to sing on the assembly or unemployment line, the United Auto Workers have put out their first album in nearly 20 years, Rising Again, sung by Tom Juravich. Included are old favorites such as Solidarity Forever and Which Side Are You On and new tunes you won’t hear on the Top 40, including Union Busting and Plant Closing. Records are $6.50 plus $1 for postage and handling from Rising Again, UAW Region 9A, 111 South Road, Box 432, Farmington, CT 06032.

Stream of Consciousness

Mad River, Hard Times in Humboldt County, is a new 54-minute film showing that woodworkers and environmentalists have more in common than is sometimes believed. Shown on PBS on September 3, it is available for rental at $95 from Fine Line Productions, 1101 Masonic Avenue, San Francisco, CA 94117. It comes with a study guide by Richard Grossman of Environmentalists for Full Employment.

Handy Work

The Directory of Workers Education 60th Anniversary edition is now off the press, containing a complete listing of labor history societies, worker education programs, international and state union bodies, labor libraries, films and tapes, college labor programs, and names and addresses of 350 labor educators in the U.S. and Canada. 68pp., $5, from Workers Education Local 189, 2832 E. Grand Blvd., Detroit, Michigan 48211.

Fair Share

Cassandra: Radical Feminist Nurses’ Network “to provide a means of sharing ideas, support, and encouragement among women in nursing practice, education, and research” is a new group looking for like-minded members. For a copy of the first issue of its newsletter, write Cassandra, P.O. Box 341, Williamsville, NY 14221.

On-the-Job Training

The National Labor Law Center, a project of the National Lawyers Guild, has just published Organizing: Safety and Health, a 32-page pamphlet for unions and workers which covers topics such as finding out what hazards are there, using the labor contract to control them, and getting compensation for injuries and illnesses they cause.

Single copies are $1 from the National Labor Law Center, 2000 P Street NW, Suite 612, Washington, DC 20036.

Blues of the Birth

Information, leads, or suggestions for a project on coerced medical treatment during pregnancy and childbirth will be welcomed by reproductive rights activist/researcher Janet Gallagher, 25 Prospect Place, Brooklyn, NY 11217.

Uncle Sam Helps You

Even in the Reagan era some of our tax dollars go for purposes other than nuclear warheads, and low-budget clinics and individuals might want to take advantage of publications from the government’s Consumer Information Center.

Among its pamphlets, most of them free, are many on general health, children’s health, and prenatal care, and drugs and medical devices.

Free copies of the current catalog are available from the CIC at Department H, Pueblo, CO 81009. Write FREE on the envelope.

Continued on page 31
Don’t Be Chicken with RICE

by Arthur A. Levin

Now that the elections are over, dinner party hosts searching for a conversation pool into which even the most heterogeneous guests will eagerly plunge together can always introduce athletic injuries. Even the minority which does not run, bike, cross country ski, swim, or play racquet sports knows enough people who do to swap tales of shin splints, locking knees, and tennis elbow. The road to wellness is often paved with pain, and many people jogging down it suffer injury, disability, and disease.

Despite this danger and the uncertainties about its precise health benefits (see the previous column, “Exercising Judgement”), most people professionally involved in health promotion and disease prevention strongly endorse properly performed exercise.

Several years ago the President’s Council on Physical Fitness and Sports asked seven sports medicine experts to rate 14 activities on a scale of 0 to 3 indicating the effectiveness of each in “promoting general well-being.” Thus a score of 21 would mean a unanimous perfect rating. The table above shows the results.

Unfortunately no corresponding rating chart exists for risks of injury, so your choices must be based solely on your personal preferences and understanding of the benefits. It is common sense to choose or continue an exercise program that you enjoy; if you don’t like playing squash, the chances are you won’t end up wielding the racquet often enough to gain cardiovascular benefit.

Inventing ways to avoid unpleasant physical exertion can easily stimulate the imagination, even of people who protest they wouldn’t know creativity if they stepped on it. Fear of strain is one of the most common rationales for not putting on shorts. This is equivalent to living on the streets because most accidents occur in the home. Exercise caution, certainly, but exercise. Many people find it enjoyable and it may have important health benefits.

Injuries can occur in all forms of exercise. The many variables make prediction—and prevention—impossible. However when mishaps strike, there are ways to reduce their severity as well as the risk of permanent damage.

Arthur A. Levin is a member of the Health/PAC Board and Director of the Center for Medical Consumers and Health Care Information, publisher of Health Facts.
Experts believe that many common exercise-related injuries will heal themselves without medical treatment. However in some cases treatment is essential to avoid a temporary or permanent end to your participation. Sports medicine wisdom stresses that you should seek medical care for the following problems:

- All traumatic joint injuries. They can become permanently debilitating.
- Injury accompanied by severe pain—take your body’s messages seriously.
- Injuries that do not seem to be healing after three weeks. A structural problem may exist that requires remediation. If pain persists for more than two weeks in a joint or bone help may also be needed.

All experts agree that prompt first aid can significantly improve healing and speed your return to the fray, track, or court.

Lovers of carbohydrates and others with a macrobiotic bent will be happy to learn that RICE is the first aid of choice—until they understand that this is an acronym for the following:

**Rest.** Stop using the injured area immediately. Continuing will not “work it out” and may extend the damage.

**Ice.** Application of ice decreases the bleeding from injured blood vessels and therefore accelerates the healing process.

**Compression.** Fluid and blood from surrounding tissues flow into and distend the injured area. Compression limits this swelling, which can retard healing.

**Elevation.** Similarly, elevation of the injured part above the level of the heart helps drain excess fluid.

Since swelling begins immediately after injury, starting RICE quickly is essential. First apply ice (wrapped in a cloth or towel to protect the skin) to the injured area. Then compress the tissue by wrapping an elastic bandage over the ice and around the injury. Avoid putting it on so tightly that you cut off circulation—numbness, cramping, and pain are signs that you should loosen the bandage.

Leave the ice and bandage in place for 20 to 30 minutes, then allow the blood to recirculate and the skin to warm by removing the bandage and ice for 15 minutes. Continue this alternating process for up to 24 hours if the injury is severe. If no elastic bandage is available, use the ice in a towel alone. If pain and swelling persist more than 24 hours, application of heat can be helpful.

While there are injuries that occur more frequently with one sport than another, there is considerable overlap. The exercise you do does not define the injury you suffer; treatment is dependent upon what has been injured, not how.

Muscles, tendons, ligaments, joints, and bones are probably the most frequent sites of sports related traumas. It can be difficult to self-diagnose the site of injury, particularly if you are dizzy with pain, but if you know exactly what part of your anatomy is hurting when you touch it, you can do a creditable job.

After RICE has been applied, how long will recovery take? That depends on several factors, not the least of which is the severity of the injury. The other factors are ones you can control—the prompt application of first aid (RICE), your willingness to rest the injured party long enough to allow healing, and what level of physical conditioning you had attained before the injury occurred.

After an injury, people who have been exercising regularly are anxious to resume their activity. Experts generally advise that if the injured area hurts when it is at rest you should not exercise it. Returning to activity means a slow reentry. You are conducting your own diagnosis and treatment plan—the presence or absence of pain is your guide (thoughtfully provided by your body) to action. It is also important to understand that this advice does not preclude finding some other form of cardiovascular exercise that will not involve any strain on the injury. If you cannot play squash because of a shoulder strain, jogging will maintain your cardiovascular fitness. Since cardiovascular fitness (and muscle strength) can be quickly lost, substitute exercise programs are essential for health maintenance while an injury is healing.

When injuries are severe, particularly if they require surgery, recovery involves a comprehensive exercise rehabilitation program to strengthen support structures. Experts believe that by strengthening the muscles that support the weakened part of the body, reinjury can often be prevented or recovery promoted.

To prevent reinjury it is important to try to understand (if possible) the factors that may have caused the injury. Some of these factors may be related to your body structure and can include structural abnormalities that place excessive strains on muscles, joints, tendons, ligaments, bones, or facets; lack of flexibility (muscles that are too tight are more prone to injury) and so-called muscle imbal-
Other factors relate to the structure of your exercise program, such as increasing the intensity and/or frequency of your activity too quickly, or overtraining by pushing too far beyond your limit. Again, the body has its own mechanism—pain—to warn you when any of these dangers arises. If during a hard workout you are suddenly hit by a pain, reduce the intensity of your activity. When that doesn’t clear it up, try rest or a different exercise. If you ignore a signal from your body, you are likely to pay by feeling pain all the time, during rest as well as active periods. When this happens, follow the RICE and recovery advice already outlined.

Listening to your body is the best insurance against severe harm during exercise. Remember, the pain is not the injury. It is a warning as well as a punishment, an advisor as well as an afflictor. With its help, you can avoid many injuries, and treat most of those which do occur yourself.

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**No Nukes is Good Nukes**

*No Nuclear News*, a monthly clipping service newsletter, offers reports from around the world on nuclear and non-nuclear wastes, nuclear weapons, "ecocide," and other concerns of the Me And You Generation. The publisher is a collective; to call it non-profit would be an understatement. Subscriptions are $7.50 per year. Send a check payable to No Nuclear News to 595 Massachusetts Ave., Cambridge, MA 02139.

**Venus de Milo**

*Media Network (208 West 13th Street, New York, NY 10011; 212-620-0878)* has an excellent "Guide to Disarmament Media" for $1.00. Its Information Center is a clearinghouse for films, videotapes and slideshows on a wide range of social issues.

**Working Poor**

The Alabama Consortium of Legal Services Programs has started a resource newsletter for groups working with low-income people. It lists organizational news, conferences, publications, etc. Write Debbie Bowling, ACLSP, 500 Bell Building, 207 Montgomery Street, Montgomery, AL 36104.

**Cold Comfort**

The Alaska Health Project is a newly-formed research, education and advocacy group. Its interests are public health, occupational health and safety, and the cost of health care. It would like to exchange ideas with other organizations about these issues. Contact Steve Kadish, P.O. Box 1037 D.T., Anchorage, AK 99510.

**Kill A Watt**

Get the latest information on the fast-moving energy issue in NIRS's newly updated (as of 4/82) Energy Fact Sheets; from nuclear waste to energy conservation. Sets on eight subjects cost $2.00; $1.00 per set if you order more than nine sets. Order from the Nuclear Information and Resource Service, 1536 16th Street, NW, Washington, DC 20036.
To the Editor:

Your Body English column is wonderful! Articles on health written in plain English with scientific references and without condescension are as welcome as they are rare.

Rachel Holcombe
Seattle, Washington

To the Editor:

I want to congratulate the Health/PAC Bulletin for being the only magazine I know aside from Road & Track which has not had an article on herpes.

Will Grant
Holyoke, Massachusetts

(continued from page 6)

This alone justifies renewing my subscription.

(continued from page 4)

provide people with firm but subtle hints that they aren't welcome. For those who need a stronger prod, the techniques she mentioned include lengthy waiting times, a cash deposit requirement, elimination of parking facilities, and unlisted phone numbers for hospital emergency departments. If non-payers are still desperate enough to keep coming, she noted that the hospital can move its ambulatory care programs out into "satellite" facilities, and "services disproportionately used by Medicaid and non-paying patients should be eliminated." To avoid any liability for the consequences, she advises, hospitals may want to alter their corporate structure.

Even so, she warns, "No doubt some hospitals will be criticized for abandoning the poor."

Not by us. We're gratified to know that although the War on Poverty may be over, the American Hospital Association is still doing its part to eliminate the poor, not only from the hospitals, but from the face of the earth.