$3.00

Southern Exposure

Sick for Justice

Health Care and Unhealthy Conditions

SOUTHERN EXPOSURE
SICK FOR JUSTICE

Special Issue Editor
Chip Hughes

Managing Editor
Bob Hall

Associate Editors
Susan Angell, Jennifer Miller
Christopher Walters-Bugbee

Editorial Staff
Marc Miller, Jim Overton, Joe Pfister,
Geraldine Robinson, Len Stanley
Sue Thrasher, Kathleen Zobel

Lay-out and Design
Mary Margaret Wade

Composition
Southern Types, Chapel Hill, N.C.

Special Thanks To:
Page McCullough, Tamsie Kane,
Cliff Kuhn, Susie Hamrick,
Amanda Ray
and the New World Foundation

Southern Exposure® published quarterly by the Institute for Southern Studies. A subscription for one year costs $10 for individuals and $12 for libraries and institutions. Address all editorial and subscription correspondence to Southern Exposure, P.O. Box 230, Chapel Hill, NC 27514. Second Class postage is paid at Chapel Hill, NC 27514. ISSN: 0146:809X. Post Office Publication No. 053470.
Summer, 1978
Vol. VI, No. 2
Articles, fiction, poetry and photographs are welcome. Send stamped self-addressed envelope for guidelines: Box 230, Chapel Hill, NC 27514.

The cover photograph of Jesse Hawkins, a victim of brown lung (see page 29), is by Earl Dotter.
The expression "Sick for Justice" comes from the interview with Square Mormon of Fayette County, Tenn. (see page 73).

Southern Exposure Volume VI, Number 2

by Chip Hughes

Sick for Justice: An Introduction

Three years ago, when I first met Talbert Faircloth and his wife, Dora, I found it very hard to believe the story that they told me. Talbert was sick at the time, and jobless and angry. Two years earlier he had been carried breathless out of the cotton mill on a stretcher, never to return to work again. I found it hard to believe that thousands of workers in the South's largest and oldest industry could have been afflicted by a crippling disease for years and not have known that they had it or even what caused it. In time, I learned that Talbert's story – like that of 35,000 other Southern textile workers – was so wrought with truth and so difficult for the region's most powerful industry to accept, that it had been suppressed and ignored for decades.

A year ago, during a conference at Highlander Center in Tennessee, I first heard Les Falk recount his experiences as medical administrator for the United Mine Workers Health and Retirement Fund. The conference brought together doctors, nurses, organizers and health workers from across the South to discuss topics and articles for this health issue of *Southern Exposure* and to share common experiences in the health field. Les Falk's recollections of the UMWA Fund's battles with entrenched coal company doctors during the early 1950s gave our gathering of Southern health activists a sense of rootedness in our region's tradition of struggle and innovation in organizing health care.

Both Talbert Faircloth – a breathless brown lung victim – and Les Falk – a crusading doctor – are veterans of the South's fight for better health care and are sick for the justice needed to cure our ailing system. This special issue of *Southern Exposure* brings together moving accounts by victims of health injustice, with the blueprints conceived by visionaries of health care reform. As we go to press, the fruits of Les Falk's labors have been spoiled by a coal industry which has callously used health benefits and medical care as a club to discipline its militant workforce. At the same time, Talbert Faircloth and hundreds of other victimized cotton mill workers, inspired by the miners' earlier black lung struggles, have dedicated their final years to building the Carolina Brown Lung Association and battling the Southern textile industry for compensation and dust-free mills.

Despite the repeated heraldings of a "New South," health has always been a major blemish on the South's robust national image. For a region which still houses the country's largest concentration of poor and underserved people, health care has traditionally meant either "making do" or doing without. Of course "making do" has had its advantages; in spite of the historic absence of the magic white physician, the South has spawned its own non-credentialed healers and backyard herbal cure-alls. From our numerous herbs and plants to our abundant healing waters, a long-buried tradition of medical innovation has been passed from the Indians to the plantation-bound slaves and onward to impoverished and doctorless whites.

A history steeped in such self-reliant traditions enables us today to try bold, pioneering experiments in community-controlled health care delivery. At the same time, however, the dearth of health services makes our region a woefully underserved "medical market" ripe for exploitation by burgeoning health care corporations and a growing medical/industrial complex.

This past decade has witnessed a veritable invasion of the health care field by corporate giants adept at managing sprawling hospital complexes, cutting costs and care, and sopping up the gravy of federal health expenditures to further fuel their cancerous growth. In fact the South houses the corporate headquarters of two of the pioneers of this unhealthy trend – the Hospital Corporation of America and Hospital Affiliates International, both based in Nashville, Tennessee.

As the practice of medicine has shifted from the informal offices of the small-town country doctor to the gleaming corridors of today's space age medical centers, the newly consolidated health care industry has increasingly demanded the production of depersonalized and stratified practitioners of assembly line medicine. The demands of the health industry have had a devastating effect on the education available in our

Chip Hughes, the special editor for this issue of Southern Exposure *is an organizer with the Carolina Brown Lung Association.*

medical, nursing and public health schools. The need for uniformity, efficiency and reproducibility – the basic values of nineteenth-century industrialization – have exacted their toll on today's students and young health professionals.

Many members of our generation have sought careers in the health care field with the hope of translating their youthful idealism into a lifelong commitment to healing the painful wounds of our strife-torn society. Yet as the participants in our opening roundtable discussion recount, the prostitution of the health education process is the most regrettable example of the new corporate domination of health care delivery today.

As we put together *Sick for Justice*, our preconceptions about health care as an inherently humane enterprise were burst apart. Though health care costs skyrocket, the age-old wisdom of "an ounce of prevention" is scarcely heeded by an industry intent on making profits by perpetuating sickness. The medical citadels of the Dukes and the Vanderbilts expand to the sky, while health care is reduced to the business of delivering commodities which relieve the symptoms of our society's sickness. The chronic ills which prolong and worsen our country's condition are ignored. The harmful side effects of unemployment, recession, and urban decay are overlooked in determining disease causation; prevention and education are dismissed as oversimplified remedies by medical practitioners intoxicated by their own technological solutions.

In addition, though our past has nurtured a rural ethic of oneness with our land and environment, the promises of both longstanding and newly-arrived industries in the South have instead produced bitter, unexpected fruits. Virginia's kepone, along with a host of other chemical compounds, has crept into our daily vocabulary as the perpetuation of our region's overall economic health – in coal, textiles, tobacco and rubber – results in disease-ridden workers, untested environmental pollutants and a potential carcinogenic time bomb. Where we live, what we eat, how we live, and where we work – formerly mundane questions – are rapidly escalating into life and death issues. We can no longer afford to treat health like a poker chip to be bargained away for higher wages or more economic growth. With each new chemical disaster, the insatiable demands of our corporate capitalist society stand in stark contrast to the ecological need for survival, self-preservation and environmental balance.

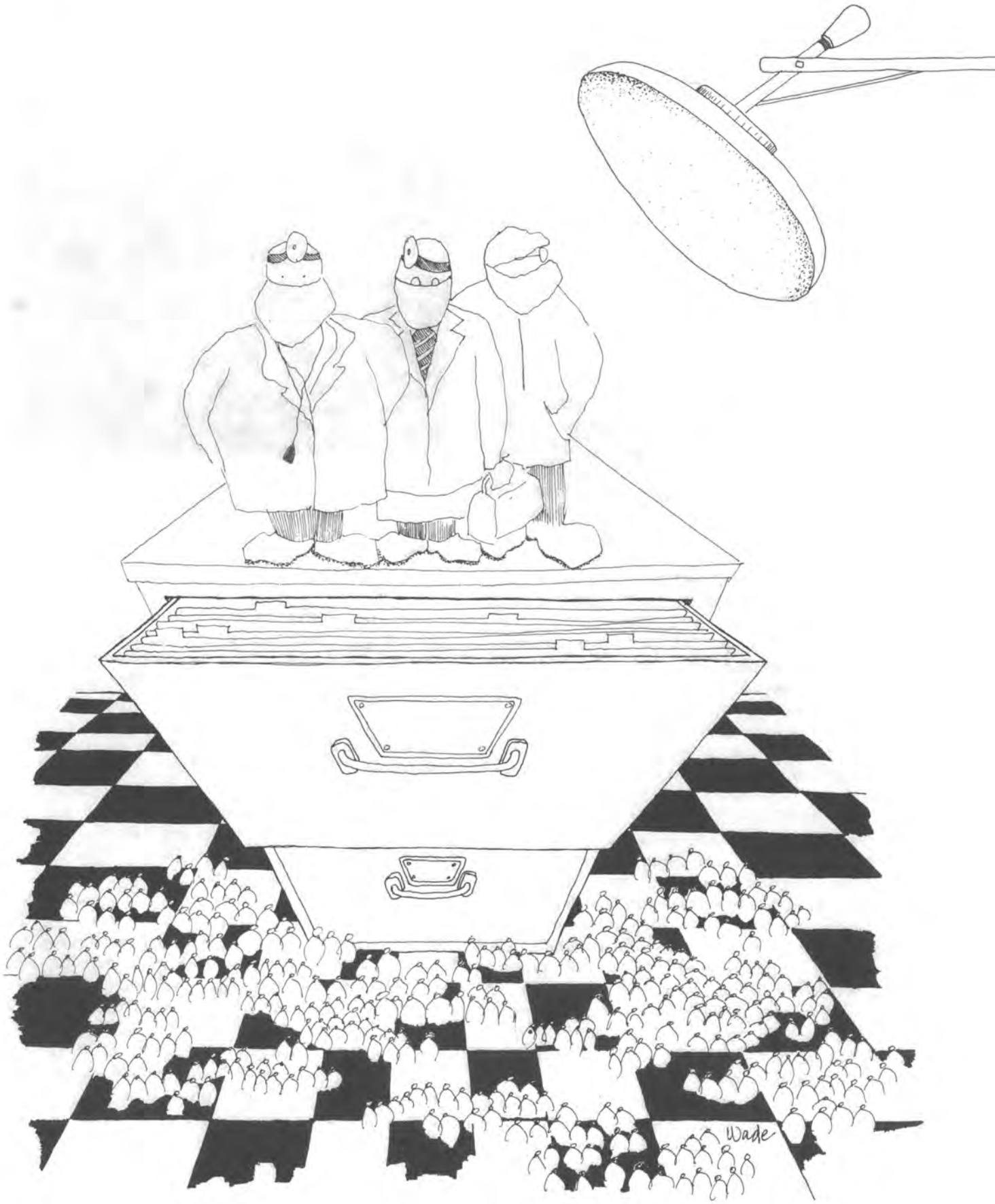
Sick for Justice was not intended to be a harbinger of environmental doom and destruction, but a tribute to the numerous individuals who have given their lives to building and revitalizing health care institutions across the South. The issue,

photo by Earl Dotter

A black lung victim inhaling oxygen

while in no way comprehensive, attempts to chronicle the struggles of health victims and visionaries by reassessing the region's numerous pioneering experiments in medical education, financing and delivery, thus laying the historical groundwork for redirecting our current system's misguided priorities. Because the solution to our most pressing medical problems lies outside the confines of our present health care system, we have worked to stretch and expand the traditional definition of "health" to encompass quality-of-life questions, political ecology, and little-noticed environmental concerns.

We have learned that organizing people around their health concerns and politicizing the question of adequate delivery of care are enormously more important than throwing dollars and experts at long ignored medical dilemmas. Although our people have been conditioned to expect magic from the great white physician and his wondrous pills, overcoming this professional mystique is the key to building institutions predicated on self-reliance, on the prevention of disease, and the wholistic treatment of individuals as inseparable reflections of their environment. We hope that *Sick for Justice* will help the victims of the present health care system – all of us – break our dependence on traditional physicians for solutions and spawn a movement across the South to take back control over our bodies, our environment and the health care institutions which were begun to protect us. □



illustrations by Mary Margaret Wade

The Making of a Health Care Professional

A Roundtable Discussion

Editor's note:

In the spring of 1977, when Southern Exposure *began planning this special issue on health care, we invited a number of people to Highlander Center in New Market, Tennessee, to discuss the topics we needed to include. By the end of the second day, it was clear that for many of the people in the room, their own training as health care professionals epitomized many of the contradictions and abuses within the system that we had been discussing earlier that weekend. As we went around the room, one person after another described how they found themselves, at first, confused and intimidated, then outraged and oppressed, by their schools' perpetuation of a health care system built around a polarized provider/consumer relationship. They found themselves forced to make choices between self-advancement and service to people, between obedience to authority and sensitivity to patients, between belief in technical answers and confidence in community control. One by one, they described their experience of fear and isolation that had dominated their years in training, fear that they would crack under the pressure, or "be found out" and purged from the medical establishment – a fate which ultimately befell several. Those of us from* Southern Exposure *were deeply moved by these highly personal stories. We knew that even if we couldn't capture the emotion of the moment, we had to somehow share with a larger audience the insights and spirit of this group of veterans from medical education. Some of the participants, still fearful of retaliation by their "superiors," did not want us to print their real names. Others went home, interviewed their fellow students and submitted additional comments, some of which are included here. The final, excerpted and edited "round-table discussion" provides, we think, a powerful statement on the making of the health care professional in America today.*

Among the participants included here are several nurses, black and white, men and women: Cindy Decker, Rich Henighan, Sybil Lewis, Winona Houser, Gloria Wright, Janice Robertson, Ed Hamlett and Rivka Gordon; professors Les Falk and Peter Wood; doctors Henry Kahn and Dan Doyle; and health administrators and activists Maggie Gunn, Irwin Venick, Earl Dotter and Robb Burlage.

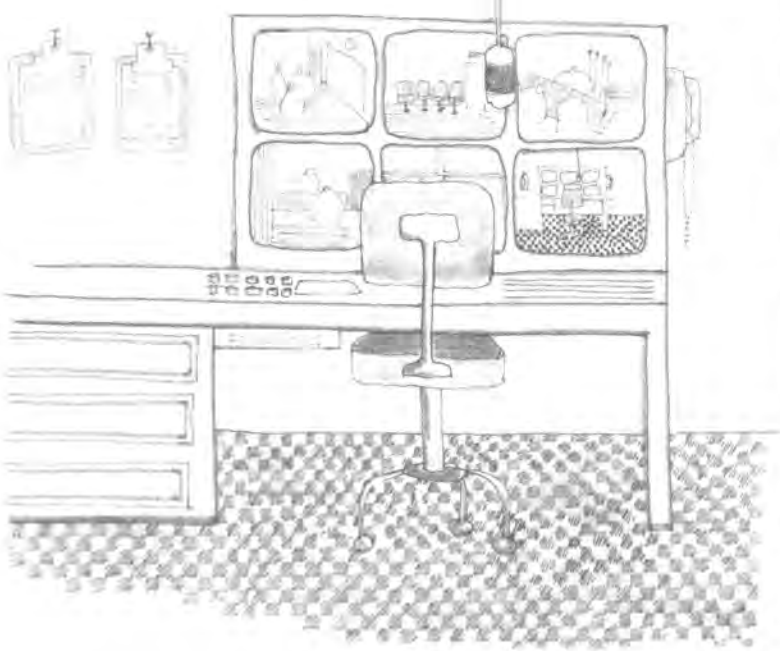
Maggie Gunn: I'd like to begin because I am getting my doctorate at the School of Public Health at a state university, and the problem there is that they don't talk about power and the goals of the health care system. What you are taught is that there are certain problems of service and they can be solved by technological formulas. It's all a question of just making the rounds of administrative techniques which have been borrowed from business schools. That's what they teach you and I'm at a liberal school. What the health system really is, who controls and who benefits from it, what is the role of the public health people in the community, can you have meaningful community input, can you have non-bureaucratic, non-hierarchical health organizations – all these issues are never dealt with.

Cindy Decker: I have a lot of thoughts about the kind of training I went through, too. I guess the first thing to say is that the education of a nurse at any level is far from pleasant. Nursing students are required to assimilate a tremendous amount of material – anatomy, physiology, biochemistry, psychology, and pharmacology are just the beginning. That is stressful in itself. But worse is the need to be a certain kind of person.

Nursing schools try to mold students, mold their personalities, the way they react to things, everything about the way they are. It happens at every level, from the way you wear your hair to the way you respond to a sexual advance from a patient or another staff member. What kind of deodorant you wear can be very important in nursing school. So can what you do with your little time off, who you live with, and whether you admit to seeking counseling for a personal problem.

Not so many years ago, nurses were trained into complete submissiveness to the doctor and even to their nursing superiors. Nursing schools and hospitals were run on a military model, which is not surprising, since nursing as a trained profession developed to serve the military. Doctors write "orders"; nurses carry them out. Today some of this has changed. Many nursing schools say that they are no longer trying to produce the handmaiden-to-the-doctor type of nurse. They teach their students to refuse orders which they believe to be dangerous or unethical, and they talk a lot about the nurse as

"There is a definite way of educating nurses which includes things like keeping files on you, observing incidents that you perform or don't perform in the hospital, or things you didn't even know existed."



an independent practitioner, capable of making independent nursing judgements, even nursing diagnoses.

But in practice, nursing education still fosters obedience to authority. And the hospital structure itself reinforces this teaching. As a baccalaureate student, we were told that we were better than the associate degree nurses, who were probably better than the hospital degree nurses who were better than LPNs who are better than aides. And it really is a "better than" point of view. What that serves to do is to divide all these health workers in hospitals up into little groups so they won't get together and say, "Wait a minute, we're all getting screwed in this hospital." There you are as an RN, you get out in a hospital – my position was a supervisor of the whole level of other people in an extremely hierarchical situation where I, as the young new graduate RN, was supposed to take charge and tell everybody else under me what to do – including those who had been there for years and who knew their jobs. They were supposed to acquiesce to my "authority."

Of course, I was put through the mill, which I expected somewhat because I had some understanding of the hierarchy and the kinds of pressures on all of us. But most RNs aren't prepared for the kind of hostility they are going to meet, and so the kinds of separations and divisions that have been set up are perpetuated. People end up being angry at the other staff instead of trying to understand what's going on. It's a very hard situation.

Rich Henighan: I went to a nursing school in what was basically a rural county, a hospital program, and it was one of the hardest experiences of my life. I really hated it. I went there because I already had a university degree and I wanted to work in the area: I thought a good way to learn more about health care in the region was to go to nursing school there. And I partly attributed the bad things that were happening to the fact that it was a small hospital program. Then, when I went to a university to do my nurse practitioner program, I found out that wasn't true, that the same things happened at this prestigious university. It was surprising. Then I learned it happened at other programs; it was normative. There was a definite way of educating nurses that had to do with things like keeping files on them, observing incidents that you performed in the hospital, or didn't perform, or things you didn't even know existed. Then, all of a sudden, somebody made the decision that this particular student was not nursing material and then they were given a notice saying you have to take a leave of absence or you have to leave.

I got a note one day from the director which said something to the effect that she had received some complaints that I smelled bad and I should

correct that and take a bath, and I should cut my hair. That was the sort of thing that happened, and I remember the way that bothered me as a personal affront. That was the level people were attacked on in nursing school; their personhood was attacked in a very bad way. Your accusors were unknown. It creates all this mistrust; I like this instructor, but maybe she was the one who reported me, or I don't like that instructor, I bet she is the one who did it.

I guess that's the thing that bothered me most about the school – the way students were treated by the faculty who were in theory trying to train them to relate to people in a caring, constructive way, to think independently and be creative in difficult environments. Yet everything the faculty did contradicted that theory – in the way they related to students, in the way they disciplined, in the way they structured classes. Someone would come in and lecture and then you had to take an objective test.

Sybil Lewis: Really, that's it. I don't mind having a hard instructor as long as they're supportive, but instead they teach you to be petty and competitive because they really do focus on things like how neat your hair is or the length of your dress.

Winona Houser: The competitiveness is the thing I found to be the most terrible. People just revel in somebody else's mistake. If the student makes a bad mistake in the hospital, everybody knows about it. And there is always the attempt, if students have been on the floor, to blame any error on them. So you have this pecking order, and again you build yourself up by putting somebody else down. But if we gave each other positive feedback and supported each other, we wouldn't need to build ourselves up by putting other people down.

Rich Henighan: There were groups of students who did trust each other. The only way that I got through school was that there were two or three other students, and we could sit and talk honestly and know none of that was going to get back to any of the faculty.

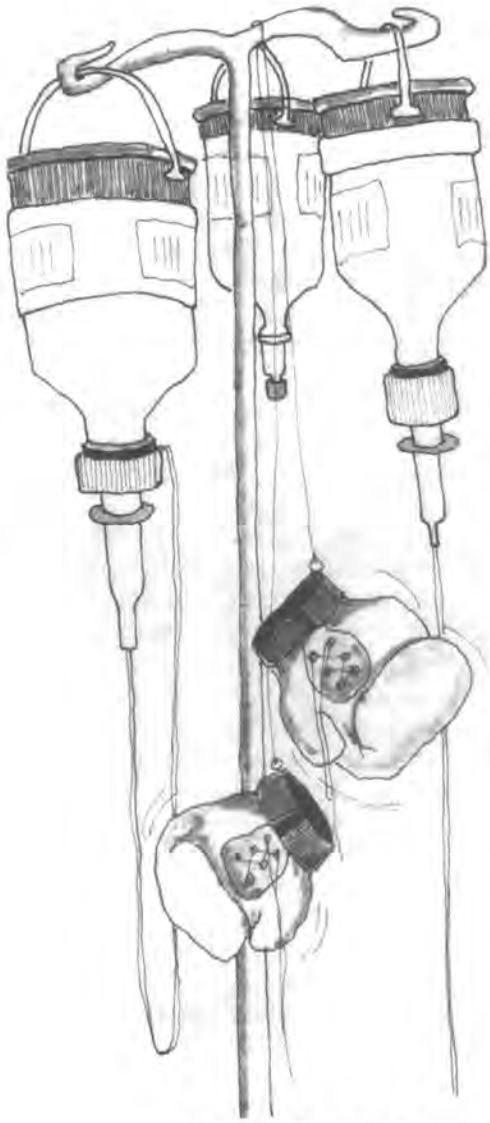
Sybil Lewis: The student really is isolated. My instructor didn't even want to be bothered by me talking to her about my problems. She was busy with law school and didn't have time to read my progress reports. All the time she was telling me I was doing good, and "Don't worry about it," and I would say, "Well, it is not showing up in the progress report," and she would say, "Oh, don't worry, don't worry." Then she called me in and said she had tossed and turned all night in making her decision, and she thought she had seen improvement in my patients and saw me communicating with my patients and said that was beautiful, but she said that in communicating on paper I was a slow student, but once I catch on, I got it. And if it was up to her, she would pass me, but because of all the bad reports in different areas, it would not be fair to other students if she passed me.

There is a sheet of paper you are supposed to sign that says you agree to the pass or fail, and I wouldn't sign it. That made her mad, but I wouldn't agree to her evaluation. So we went to the Dean's office. It was sad because there was no way the decision was going to be changed. The faculty and Dean all stick together. So it really didn't matter how you plead your case; you had no input.

"The competitiveness is the thing I found the worst. You have this pecking order, and you build yourself up by putting somebody else down."

Gloria Wright: It would be fine if they wanted to help you by pointing out your weaknesses and facilitating you working with that weakness, but it's not that. It's "You're weak in this area, go work on that, go talk to so-and-so." All they do is pass you off. It's like you're the black sheep and they can't find a place to put you. I wouldn't want any of my sisters to go here, except maybe my baby sister who has been in integrated situations for over ten years; she has her own determination and doesn't let what people say about her bother her any.

Janice Robertson: If you don't fit in, they'll use your weaknesses against you. I was called in for a review of my latest progress report two weeks before the end of the semester, and told it was not passing and I could repeat the course after I took a leave of absence. I had received A's on the midterm and papers before that. The same thing happened to Sybil that same week. The fact that we had gone to the Dean to complain about one instructor having so much power and that I had begun talking to students about the right for a hearing on such decisions, may have influenced the evaluation. There wasn't any direct proof that my "unprofessional attitude" – working in a community-run clinic, becoming friends with patients – had any influence, but a disapproving eye was felt. That semester nine students were asked to take a leave; seven were black. None of us had flunked the term papers, or tests, but our clinical instructors in a one-to-one setting had told us each that we just wouldn't make it. That's where they used our individual weaknesses or vulnerabilities against us. For me, I had trouble with the sight of blood. I was working on it with a counselor, but it was not interfering with my clinical work at that time. But my instructor just said I'd never get over that fear and I couldn't make a good nurse.



"They teach you to be petty and self-promoting. Competitive impulses are nurtured."

Sybil Lewis: I do find it hard to be black and in this situation. Little things happen all the time. Not long ago, the Dean was speaking at a convocation and said, "It is predominately white, but now we have fourteen blacks," like "We have our token blacks." She may not mean anything by that, but why bring it up? It is so cold the way it is said. Anywhere else, it would be an accepted fact: "Of course you have blacks," but here it is, "Look what progress we have made."

Rich Henighan: The official line is also that they want men in nursing, and they are glad to have men in nursing. I think it comes out of the belief that the more men who go into nursing, the less it has the "pretty little girl" image. Also, the more men who go into nursing, the higher the salaries go. It is just one more iron in the fire to get the changes they want.

Ed Hamlett: I was a technician for three years before going to school, and I got lots of encouragement to go into nursing. But there is a kind of sexism involved in my work now; it gets manifested in always being assigned to male patients because they don't trust me or because they sensed female patients wouldn't like me giving them a bath. Women nurses were assigned to both men and women, so there was a double standard.

Janice Robertson: I think that ties into what we were saying about how division and separations are perpetuated with the nursing ranks. Even the nursing literature is filled with challenges to the old stereotypes of a nurse being incapable of independent reasoning and always subservient to a doctor. There is now a fiercely independent streak among nurse associations, which is in contrast to the team approach and supportive role nurses played, to the very nature of or perhaps the very uniqueness of the nursing role. So not only are the competitive impulses nurtured between doctor and nurses, but also within nursing students themselves and between them and their fellow nursing workers.

Cindy Decker: The changing role of women in general in our society has something to do with this. Strong women are generally working into positions of leadership in nursing. I don't think they have a very good analysis of why things are the way they are, but at least nurses aren't just saying "Yes sir," or "Yes ma'am" anymore.

Peter Wood: Except when you recall the history of nursing and its beginning within the military, the original women who cracked the structure made their reputation as anti-bureaucrats; they so publicized the bad medical care during the Civil War that the generals couldn't shut them up.

Rivka Gordon: There are all sorts of mixed messages; you're never exactly sure which way you're supposed to go. On the one hand, you are supposed to assist the doctor; on the other hand, you are supposed to have the interests of the patients at heart and that's why you're different from doctors.

Rich Henighan: The "best nurses" somehow manage to appear to the physicians to be basically making life easy for them, but at the same time somehow manage to provide care to the patients in some assertive way – you didn't just do the minimal amount. The lesson was to try to find ways, without directly challenging the physician, to find ways to meet patients' needs that perhaps were not being met.

Ed Hamlett: I remember being told, "Whenever you are doing a sterile procedure, you always take an extra pair of gloves in with you. Then if the doctor breaks sterile procedure, you can tact-

fully say, 'Doctor, I have some sterile gloves here if you would like to change.'" So there was recognition that nurses did carry responsibility for caring for patients, and that might mean suggesting that doctors do things a different way or that might mean not giving the medicine in the dosage ordered. It was always very clear though, that we are not colleagues with the doctor; it was pretty clear who was God in that situation and who was not.

Winona Houser: Oh, respect the doctor, he is most holy. They tell you that the doctor should help you, but he thinks you are subservient. When you're a student following the doctor around in the hospital, they tell you, "Don't ask him any silly questions." But if it is something you don't understand and this silly question is going to facilitate your understanding of the patients' conditions then I feel like you ought to ask your silly question. They make you feel very humiliated.

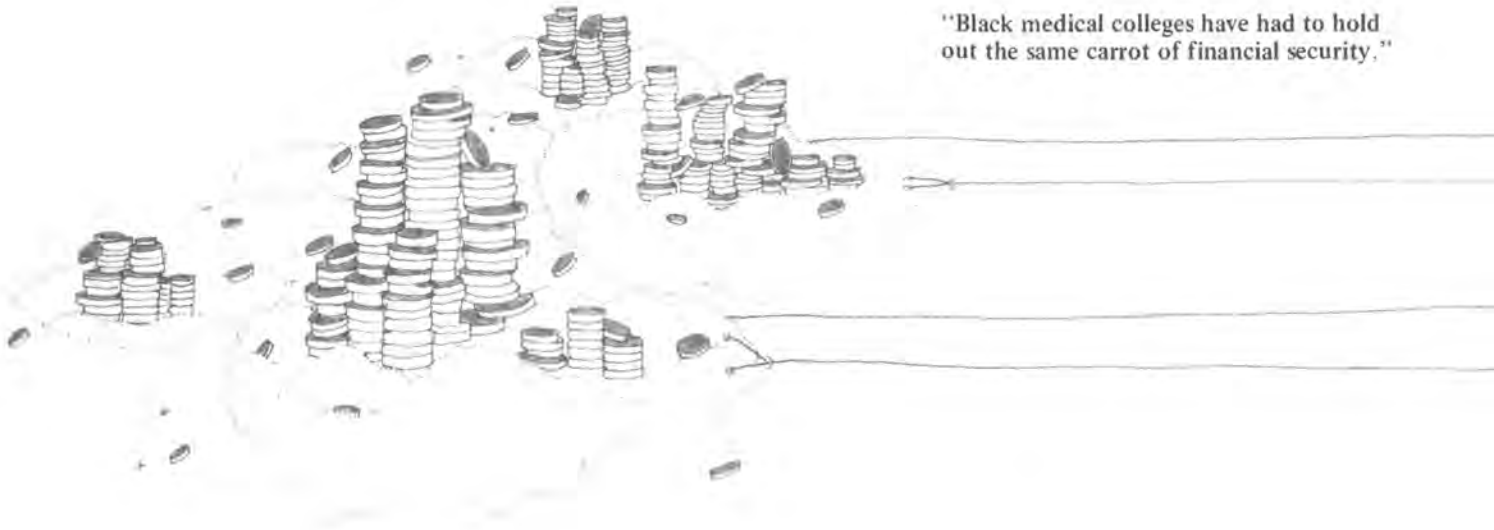
Janice Robertson: The whole thing really is a dehumanizing process, and I wish I had realized that before entering nursing school. Persons become objects which you do something to. Patients are identified as the liver in Room 202 or the post-op in Bed 1, to which you do the nursing process to. In a way, the whole mystique about medical and nursing diagnoses is also reinforced, and you're supposed to believe that you are learning these great secrets that separate you from the rest of the society. I experienced an incredible struggle of vigilance to keep in mind that the actual information about how our bodies function is not some mystery reserved for the privileged few.

Henry Kahn: I've been listening to this discussion of the socialization process that goes on in nursing school and comparing it in my mind to what happens to doctors and to my own background. I think for the physician, the important thing is the selection process by which he or she gets into medicine in the first place. It's a highly personal, self-promoting kind of thing. It may be influenced by family, but it rarely gets beyond the family in terms of community responsiveness, and that's perpetuated all throughout the training process. You know by the time you get out you're in it only for you; you know that there is a warm bed that you are making for yourself. Anyone who is interested in health for purposes of community responsiveness is very unlikely to get beyond junior high school as MD material. The selection process starts so early that the candidates who come before the admissions committee at medical school are almost uniformly oriented toward personal advancement. At the moment, there is some required rhetoric about family practice, rural care, serving the under-privileged, and so forth, but the words are illusive.

The MD selection process is so self-centered that everyone who's in it can be counted upon to accept socialization on their own without petty harassment. By the time they get to professional school, and beyond that to the rigors of internship and residency, the pain is a very traditional kind of pain – excessive maybe, but just long, long hours of very fatiguing work circumstances. Compared to the nurse's experience, there isn't much hassle on the juvenile disciplinary level, although that is there for the person who does not toe the line and show some obvious respect. In general, the costs and the duration of education are so great that none but those who are already in a class that's self-serving can even think about it. There are exceptions – I hope there are some in this room – but it's hard to know how we might be exceptions fundamentally when you find out where we're coming from and what we really think we're going to do and how much can we, despite our intentions, really respond to community interests.

Physician education is limited pretty much to upper-middle-class people, whereas nursing candidates can pretty much come from any class, especially if you consider the hospital programs. There is an alternate channel of nursing that really traditionally has come out of working-class women. Nothing like that in medicine. The worst of it is when occasionally you find exceptions – working-class people who make their way up to the medical admissions committee – their socialization is often stronger than anybody else's to make it up to the independent self-serving style that characterizes traditional physicians.

"It was always clear that nurses weren't colleagues with doctors. It was pretty clear who was God."



"Black medical colleges have had to hold out the same carrot of financial security."

Les Falk: I teach at a place, one of the two predominantly black colleges, and certainly there has never been a period of history with enough rich black families to account for admission to Howard University and Meharry Medical College. What has been necessary is holding out the same carrot of succeeding in good income; they offer opportunities for independence which are pretty rare in human life and in return for that, there hasn't been the graduation of very many allies with social change movements.

Nursing and physician education literally isolate the student into these kind of self-serving, internally competitive structures. I think it is extremely important that there be activities and efforts within the medical school framework, the health system framework, for students to experience the difficulties of people going bankrupt getting commercialized care, to get students out of the nest into real life and attempt to get them in contact with communities. But I think we should be very careful not to confuse a student's experience with a health fair or community rotation with a real understanding of what social organization, community organization, consumer leadership, what an egalitarian relationship really is. If you want to make a contrast, just take the example of how many faculty members in the US do farm work or factory work in order to learn the conditions of life as our Chinese counterparts would do.

Dan Doyle: I'd like to say a little about my experience of socialization in medical school. I feel that was a very personal struggle for me. A lot of criticism of the process can be made, but the main unifying theme that I can see picks up what Henry and Les are saying about selection and accountability. If you are admitted to medical school, you are not selected by your commune the way you might be in China; you are self-promoting, self-selecting, fighting your way in. And when you get admitted, the one thing that is emphasized to you throughout the whole four years is your importance as an individual. The worst mistake you could ever make would be to submerge yourself in some kind of an egalitarian system or in some kind of a cooperative effort because you wouldn't really be fulfilling your *personal* potential.

Anytime you tend to stray off the path, they don't so much pull out a personal file as hang over your head the possibility that you might be eternally lost because you aren't proceeding along the path of individual accomplishment. I was thinking there are two camps of people; the cynics and the liberals. The cynics are those people who constantly keep saying, "Oh, you can never do that, I thought that too a long time ago; but I realized that people are all no good, and patients are all out to take advantage of you and sue you. You better just watch out for yourself and get the best job you can." That's usually said to you at a time when you've been working for fifty or sixty hours straight, so you're already beaten down and inclined to believe the worst.

Then there are the liberals who make some overtures to social change, but always in a way to support their professional identity or agendas. Like if you're interested in social change, they don't say, "Well go work in a factory awhile and see what it's really like"; they say, "Well you ought to take a year off and get a masters in public health or public health administration." Because if you are interested in social change, the way to achieve it is through a professional, elitist approach – become a health planner, community medicine, do some research on distribution of health care. In any case, do it in an individualistic way, and that continues on into when you choose your residency – look for the best place, look for the best future for you. So if people finish that system and decide they

want to be involved in community health care, they sit down in a situation where they are faced with a community board. Initially, there is a conflict because people come in there with a sense that they are going to do something *for* that clinic, and with a lot of ideas on how it can be done. Either they fail, or they go through a period of re-education, after years and years of emphasis on the individual's importance.

Southern Exposure: Why are so many people getting into health? I'd like to hear from the people who are involved in it, what they see as the personal reasons for the increase in so-called health professionals among "socially aware" people. Is it an avenue where in the '70s you think you can combine the ability to make a living and survive with some sort of social expression?

Dan Doyle: I think it's because it's an easier area to compromise. I think it's an illusion to think that just because you're involved with health and taking care of and serving people, that it somehow naturally contributes to social progress. A lot of people who are idealistic and who clearly don't want to be associated with being in big business, or in an obvious expression of the profit system, gravitate to health because it allows them to harbor their idealism a little bit longer.

Rivka Gordon: I don't think that's a total picture. I think that the more people know about health as broadly defined, their own health and the communities' health, the more they can become self-reliant, and the more people become self-reliant the more power people have to make changes in the system as a whole. As long as we have a really unhealthy population, psychologically, physically, housing and education – all those things – then people can be more easily controlled. I don't see health as only providing medical services at all. In fact, I think that the service aspect of it is one of the parts of it that I have the most problems with, although I am involved with direct patient care; I question that a lot. I think that it's a way to help people become more self-reliant.

Earl Dotter: I am a photographer who is also concerned about health issues. It seems to me that health is an issue that really is where our capitalist system is vulnerable, particularly in occupational health. We have a cancer epidemic which everyone in this country can identify with. For me focusing on problems of worker illness at this particular time, I think quite a bit of the larger population can perceive what that's about as their mother, father, or daughter, fall apart in front of them from the diseases that are confronting everyone caused by our industrial society. It seems like it's a real large area to organize from that affects virtually everyone in this country.

Irwin Venick: It strikes me that there are two parts to the question: one, why is there a gross increase in the amount of people going into health? I think the simple reason is there are a lot of dollars in health, and it's an expanding work market; you have health planners, health administrators, etc., etc. It's a growing industry. The more interesting question is two – is there a disproportionate number of political people involved in health? If that's the question, I think that Rivka is sort of on target cause I think it's easier for people to make an association between working in some sort of health area and expanding into some sort of political activity than from other areas.

Robb Burlage: I think the contradictory expansion of the medical/industrial complex in the South is a reason why political people would want to relate to it. The resources are there, and the outrages and misuses are there. But the question of how we deal with those contradictions goes back to the personal, political level, to the idealism about our working formations and community advocacy. I think if we're honest with ourselves, we have to recognize the extent to which we are supporting community health clinics which are trapped, which aren't able to move beyond the formations they are in, the extent to which we are on the edge of the trade union situation advocating occupational health, but can't get any further. To talk about taking on the contradictory expansion of the health system sounds idealistic. We have enough trouble just keeping going, keeping the Brown Lung Association supported or a community clinic surviving in the bureaucratic maze. I think this kind of struggle we're in has to do with the whole political cycle in the country, in which there is not enough mass movement obvious in any area to move people forward and force them to change self-critically and in which people feel they need to be partly protected with a certain amount of professional access or a job security of a kind. I think a lot of people who have been washed up into areas of health activity are trying to be creative in it and shouldn't be grandiose. One of the nicest things about today's discussion has been talking about eye-level experiences in medical education, attempts to keep activities going at the community health organizing level, and how to be serious about the overall problems of the health industry's growth contradictions while helping each other survive. I think this is the balance that has got to be struck if we're talking about strategy. Otherwise we extol the community experiments on one hand, and we talk about all the alienation we experience in our own medical education on the other hand, and we don't relate the two. That putting-together is exactly the problem we must face personally and politically with others in this room and in the community at large. □

The Struggle

by Michael Freemark

A struggle now rages within me.

It is the struggle of transformation and of resistance, of human necessity and human isolation.

It is a struggle which pierces the depths of my being, and one which I have not been able to resolve.

It is a struggle which is slowly destroying me.

I often thought about that struggle while standing in my shower, eyes unopened, lips parted, body drenched and warmed as water pounded upon my head. A certain faith and a measure of inexperience had enabled me to move aggressively and ambitiously through medical school – faith and the conviction that so long as I was skilled and devoted, I could lend assistance and relief to others, and serve them responsibly in a way which would assure mutual fulfillment. The key to both society's well-being and my own individual happiness was above all a tactical matter requiring a certain emotional readiness and long painful hours of study.

But reality had weakened my firmly held convictions. It soon became clear that any service I could provide was merely symptomatic and short-lived, too little too late. The health of my patients was shaped by societal forces over which I had no control, of which I had little understanding. Neither I nor my patients could find any lasting satisfaction in such an arrangement, and as things stood, there was little hope for change.

Michael Freemark is a pediatric resident at the Duke University Medical Center.

Such distressing thoughts are not easily tolerated, and on this particular morning, I wiped them from my mind as I wiped drops of water from my arms and chest. In haste, I donned a stained white uniform, kissed Anne on the forehead, and for my breakfast, ate a plum on the way to the car. The engine turned over immediately (this always lightened the day's burdens), and in no time I was headed for the hospital.

It was later than I had first thought, and after parking, I slung my knapsack on my shoulders and ran (slowly, in order to maintain composure) to the main entrance, already bustling with activity. A security guard guiding a young child in a wheelchair swung the front door wide, allowing my passage as well. Sliding past three nurses I moved breathlessly to the elevator, only to find it tightly sealed, leaving me to shuffle my feet stupidly and glare at the flashing lights.

The elevator door finally opened and I stepped in to find two elderly black ladies, one toothless and smiling, plaited and wrinkled, the other rotund and grey-headed. They were draped in drab yellow cotton workshirts and were clutching mops and pails of soapy water. Their nametags read "Environmental Services." Their intimate chatter ceased abruptly when I entered.

The integral parts of great medical institutions move deliberately and with purpose. This elevator was no exception; it was programmed to stop at each and every floor whether or not anyone wanted to get on or off. Thus there was time for a conversation, though it was highly unusual for one of us to converse with one of *them*.

I am not sure why this was so, though a friend had once explained that she simply couldn't understand them, nor they her. Nevertheless, the toothless one continued to smile at me and I was forced to say, "How y'all doing?" She replied wryly, "Well, two people vomited up on Halsted ward, and one of the toilets on Sims overflowed. The day ain't looking so bright."

Her lack of restraint surprised me; I was not accustomed to such candor. Still, hers deserved a response. "I know what you mean," I said. She shook her head and laughed heartily, in a way which only confused and embarrassed me.

We had reached the fourth floor and I walked quickly out of the elevator and down the hall to the nursery. Two medical students, an intern and the staff physician were waiting when I arrived. I quickly gathered my notes and we began walking the rounds of babies born on the previous day. The first two admissions were relatively uninteresting – two active full-term children; Baby Boy Taylor was differ-

photo by Jackson Hill

ent. He was small, floppy, and had the slanting eyes and facial features which we recognized as typical of Mongolism. The staff physician expounded upon the nature of this disorder, referring to the boy as the "Little Down's," and concluded by stating emphatically, reverently, "Mongols have a variety of problems, but they are all retarded, and they all look alike."

We decided to visit and talk with Mrs. Taylor, who was watching television in her room. She was a thirty-eight-year-old Lumbee Indian woman who had spent her life in eastern North Carolina. Her skin was the color of crimson and slate; she had long, straight black hair and a quiet but firm voice. This baby was her sixth child; she was accustomed to uninvited physicians and well-meaning "student doctors."

The staff physician spoke first, smoothly.

"Hello, Mrs. Taylor. We've come to speak with you about your little boy. Have you seen him yet?"

"Yeah, ain't he pretty? I'm gonna name him Johnny after his father."

"We have certain concerns about the child."

"There ain't nothing wrong with him, is there?"

"He seems to be doing relatively well now, but. . . "

"That's good."

He spoke more sternly and slowly. "But we are concerned that the child is quite small and floppy, and is a slow feeder. We are not certain now, but there is a strong possibility that his psychological and motor development will be significantly delayed as he matures." He paused for a moment and then continued, "He will very likely be a happy, playful child, but a slow child, slower than other children his age."

She looked at him solemnly. "Slow."

"Yes."

After a minute of silence, "I'm not sure about all of what you doctors say, but I think he's pretty, and I want to take him home and nurse him. When can he go?"

"In another day or two. We'd like to watch him for awhile. Dr. Freemark will be back to speak with you again soon. Try to get some rest."

"Okay."

We discussed the problem outside her room. Again the attending doctor spoke, understandingly, with concern and a bit of a smile.

"Her psychological defenses are difficult to penetrate. She utilizes her strong maternal instincts in order to drive real conflicts from the domain of consciousness."

We nodded perfunctorily.

"She's obviously of limited intellectual capacity, and at times these people have difficulty verbalizing or even understanding their own emotions. She may never come to grips with feelings like anger and guilt which lie beneath the surface."

The rest of the morning was uneventful. We stood by uselessly as an otherwise healthy child was delivered by Caesarian section. I spent two more hours plodding through my talk, "taking care of your baby at home," for each of seven new mothers who were soon to be discharged.

Lunchtime was fast approaching and, to avoid the rush of humanity and the long lines in the downstairs cafeteria, we decided to dine on the third floor with the other doctors. As we filled our trays, I noticed that the intern with whom I had made the morning rounds was unusually quiet and visibly upset. When we sat down, I asked him what was on his mind. He blurted out angrily, "It's just infuriating. This woman is thirty-eight years old, on Medicare, and has her sixth kid who's a Mongol. She thinks he's pretty now, but in a few years she'll turn him up for adoption or institutionalize him; and you know who'll be paying for it."

"Oh, knock it off. People like her put you on the map."

"She's a leech. And when a leech takes hold and starts to suck, you've got to rip its head out before it drains you."

"She seems to love the kid."

"She doesn't know what love is. Love is having a kid you can support with your own money. She just loves getting screwed and doesn't want to know any better."

"You're full of shit."

"Ahh!" waving his hand contemptuously.

In order to maintain good working relations, we avoided discussing the subject further. That afternoon, I returned to Mrs. Taylor and found her sobbing quietly. When I sat down by her bed, she reached out and lightly touched my arm.

"My baby ain't right, is he?"

I shook my head slowly. "No."

"I knew it from how the doctor was speaking to me, in ways I couldn't really understand. I knew it myself when I saw him the first time; he didn't cry like my other babies."

Her eyes suddenly grew dark and driven. "I raised five young 'uns to where they could make it on their own. This one ain't no exception. Different or no different, he's mine. I ain't had much luck in my time, and some of what I deserved I never got. But what's mine I earned, and ain't nobody gonna take it from me."

As I sat staring at her, I recalled again the words of my friend. She had been right – I really couldn't understand them. I feared their desperation and their power; their world was too intense, too real. More than anything I wanted simply to leave Mrs. Taylor. I rose, and moving slowly to the door, opened it awkwardly.

"Goodbye," I said, "I wish you well," and walked down the hall, empty and alone.□

A Century of Service
Meharry Medical College

by Leslie A. Falk, MD

photos by Vernon L. Smith

Leslie A. Falk, MD, is co-author of a history of Meharry Medical College, now in manuscript form. He has been Professor and Chairman of the Department of Family and Community Health at Meharry Medical College since October 1, 1967. From 1948-1967 he was Pittsburgh Area Medical Administrator for the United Mine Workers Welfare and Retirement Fund, working mostly in northern West Virginia, Ohio and Pennsylvania. Civil rights events, especially during 1964-65, and changes in the UMWA led him back to the South where he had originally worked with migrants in Atlanta during 1947-48.

Photographs courtesy of Meharry Medical College, Kresge Learning Resource Center, Nashville, Tennessee.

Photos above are of the Walker Health Center in Nashville.

A meeting held the night of Friday, March 10, 1978, at Meharry Medical College in Nashville, Tennessee, was delayed for over an hour because of a bomb threat. Those attending were then warmly welcomed by Lloyd Elam, MD, President of the College.

What kind of medical college gets bomb threats? What kind of meeting does it hold which precipitates a bomb threat? What kind of college president gives a rousing statement supporting the students for holding that meeting? What kind of Friday night event attracted persons so used to bomb threats that, once evacuated from the building, they stood outside and burst into group singing – the commonest word heard being "Freedom"?

The meeting was the opening session of a Conference on International Sports, Politics, Racism and Apartheid, held to express solidarity with the suffering black people in the ghettos and mines of South Africa, to back the United Nation's condemnation of the racist South African government, to demand cancellation of the Davis Cup tennis matches between the South African and US teams to be held in Nashville at Vanderbilt University, March 17-19. The demonstrations and protests that next weekend were the greatest outpouring of US and world protest against the hypocritical racist policies of the South African government in recent years.

Meharry faculty and housestaff provided health services during the protests and in so doing demonstrated agreement and involvement.

Dr. Elam attended every session of that weekend conference, and spoke clearly and movingly of its importance. He recounted the insults he had personally experienced during a recent official trip to South Africa. He welcomed the official United Nations representatives who informed most of us for the first time of the numerous General Assembly Resolutions opposing the quasi-slavery (Apartheid) of South Africa, including the importance of expelling South Africa from international sports events. In 1977, Vanderbilt University earned $1.4 million from its investment in corporations doing business in South Africa, where whites are paid on the average seventeen times more than blacks. The

meeting was thus particularly critical of Vanderbilt University for its persistence in hosting the tennis matches despite world-wide shock and protest.

Was this event a freak? How did a medical school, from its president on down, get involved in protesting racism in South Africa? How had the school, its students and faculty responded to the challenges of segregation, impoverishment and discrimination in the past?

Meharry's president, Lloyd Elam, and the life of his institution gives us much insight into the answers to these questions. Dr. Elam is Afro-American, the son of a Little Rock, Arkansas, carpenter. His mother taught him at an early age that the family should walk whenever they went anywhere, rather than ride on the city's segregated street cars and buses.

Dr. Elam, like Meharry, had battled racist odds to survive through the years. In 1976, he reflected on the Meharry mission as the college celebrated its hundredth year of operation: "Meharry Medical College enters its second century with a tempered confidence. So long as poor and sick people are denied care that means health and life, we know how steep the climb will be. We can help meet the vast and complex need only by learning how better to deploy skills equal to the tasks.

"We have come through the worst of times. We inherit the tradition that trained emancipated slaves to be physicians and dentists."

A Need For Healers

Black people called doctors have been identified in the United States as early as the seventeenth century. By the 18th century, slaves, especially males, were forbidden the healer role by law in most states. The reasons were political, cultural and simple fear they would poison their masters.

Whites also knew that healers' mobility among the black populace might aid potential slave insurrection. For example, the Tennessee Court ruled in 1844 that slaves could not practice medicine because "such doctors might foment insurrection," and fined a plantation owner for allowing such a practice.

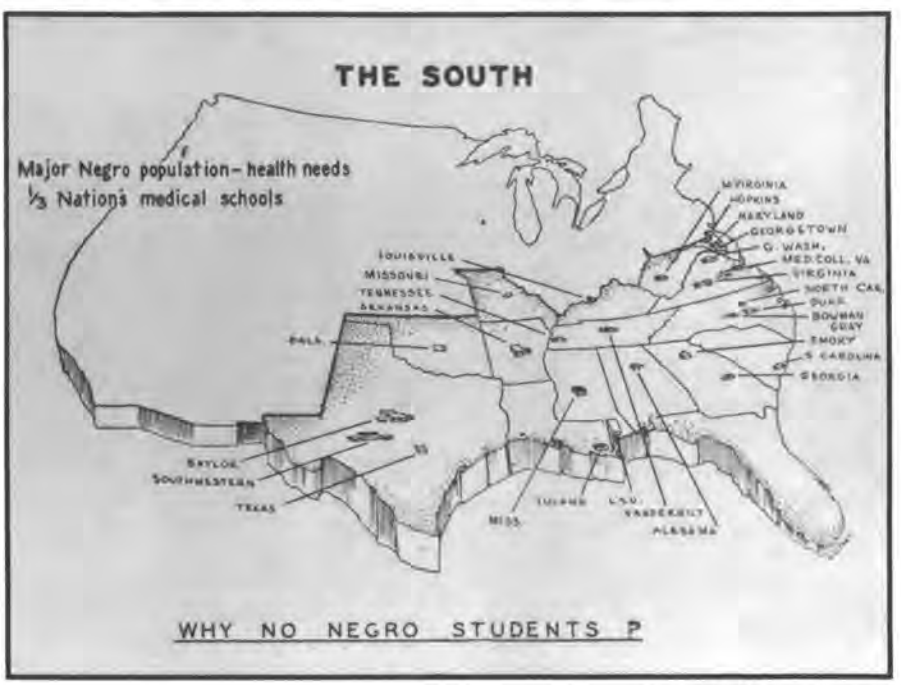
When the Civil War broke out, Union troops occupied Nashville and remained there until the war was ended in 1865. The emergency needs of the sick, malnourished and war injured, combined with yellow fever, cholera, smallpox and other epidemics. Endemic diseases such as malaria, typhoid and dysentery continued unabated. As the decade wore on, these conditions helped some whites recognize the need for blacks to receive medical training.

Meharry Medical College grew out of an unusual set of post-Civil War circumstances. George W. Hubbard, a white Northern Army Medical Corpsman, stayed in Nashville after the war ended and attended Nashville Medical School, which later became Vanderbilt Medical School. He was offered the opportunity of adding a Medical Department to Central Tennessee College, a college for freed slaves begun in 1866, by the college's president, John Braden.

In October, 1876, Hubbard joined with W.G. Snead, a former Confederate Army Surgeon, and seven part-time white doctors, under the sponsorship of the Methodist Episcopal Church. Financial assistance for the project came from the Meharry brothers, five Midwestern abolitionists of Irish ancestry. The school began educating former slaves and children of slaves. Meharry's early graduates returned to the disease-ridden city streets and the impoverished countryside of the post-Civil War South.

When Meharry began, it consciously rejected the goal of merely training what we now think of as licensed practical nurses or lower level health workers. Meharry's early striving for both equality and excellence grew out of the expression attributed to W.E.B. Dubois that black people should be able to do anything as well as white people. Meharry's mission focused on enabling black people to become both community leaders and medical practitioners. The founders hoped that the religious aspect of healing would be expressed; as a result many of the graduates were ministers or highly religious physicians.

Meharry graduates later confronted head-on the dilemma posed by the debate between W.E.B. Dubois and Booker T. Washington concerning the proper role for blacks in changing a racist white society. Every activity in a black doctor's life presented the challenge: whether to compromise with white society or stand for civil rights. White doctors would not see black patients in their offices, except perhaps during segregated hours and in a separate, undersized waiting room. Hospitals would either not admit black patients or have a special ward in the basement for blacks, obviously inferior to the services and facilities for whites. In these circumstances, the black doctor had to be willing to suppress many normal attitudes of self-respect and independence. To get through medical training required financial and other kinds of support from white men with



from a 1948 NAACP report

"The key to Meharry's long life has been its ability to thrive, learn and grow through struggles which constantly threaten its survival."

power in the community. And those allowed to graduate were expected to play the role of the educated "pacifier," to insure that lynchings, beatings, robbings, and various other misdeeds done to the black community did not elicit reprisals.

Black doctors patched the walking wounded and did their best to keep society stable to avoid conflict and trouble. Technological knowledge and skills were stressed at Meharry. Hard work with no relief became the lot of the college's graduates. In the cities, they developed Negro hospitals to counter the segregated wards of the white hospitals. Many Meharry graduates were never able to obtain hospital privileges in white health care institutions. But black people in the South were in desperate need of health care services and they proudly embraced their own providers.

In 1877, the South's long dreamt-of black medical college graduated its first class. By 1882, the graduating class numbered eight, and among them was Robert F. Boyd, perhaps the greatest Meharry graduate of the nineteenth century. Dr. Boyd was the first black doctor to open a private practice in Nashville. He helped found the National Medical Association (NMA), the first organization of black physicians in the United States, and became its first president in 1895. The NMA was founded because the American Medical Association (AMA), and almost all state and county societies persistently banned black physicians from membership. As Meharry's first professor of hygiene, Boyd wrote an important paper entitled, "What are the Causes of the Great Mortality Among the Negroes in the Cities of the South, and How is that Mortality to be Lessened?" – a question which our present medical establishment has yet to answer. Boyd invoked the goddess of health (Hygeia) and pointed to overcrowding, unsafe working conditions, impure milk, spitting in public, improper diet and lack of health education as the answers to his question. This was the best public health thinking of his time.

In addition to his medical practice and health education activities, Dr. Boyd headed the Nashville Anti-Tuberculosis Association, a chapter of the first voluntary health association in the United States. In responding to the challenge laid down by W.E.B. Dubois, Dr. Boyd did not eschew politics. Even during the dark days of the Ku Klux Klan and racist power, Boyd ran for mayor of Nashville in order to bring the needs of the black community to the public eye.

By 1910, the waves created at Meharry and its sister school, Howard in Washington D.C., were rippling across the South. There were now seven black medical schools including Flint in New Orleans, the University of West Tennessee in Memphis, the National Medical College in Louisville and Shaw Medical College in Raleigh. During that year, Abraham Flexner published his widely touted report on medical education in the United States, with the support of the Carnegie Foundation. The Flexner Report had many important insights, but it also sounded the death-knell for the growing black medical education network and laid the groundwork for consolidating Southern medical education in the hands of a small number

of elite white medical schools closed to black students. Only Meharry and Howard survived, as the number of black doctors dropped dramatically.

In spite of the glimmer of hope created by Meharry's stubborn survival, its efforts in health care delivery and medical education were but a drop in the bucket, as all health indicators continued to reveal the South's and the nation's shameful neglect of black people.

Black Health Today

Practically all major indicators in health, health service and health personnel are much worse for blacks than for whites. Infant mortality, that inescapable indicator of the public health status of a population group, remains strikingly adverse for black Americans. The American Public Health Association's *Health Chartbook* shows the 1971 black infant mortality rate as 30.3 deaths per thousand live births, almost double the rate for the white population.

Black youth is similarly ravaged. Today's violent urban environment subjects black people to a disproportionately high risk of death from homicide or suicide. High unemployment and dead-end ghettos breed and spread devastation from drug addition, theft, juvenile delinquency and unwanted pregnancies.

Statistics on black participation in the health care system are equally dismal, in spite of the progress that has been made. Although over 350,000 black people worked in health-related jobs during 1970, two thirds of them worked in lower paying positions as orderlies, attendants, nursing aides and practical nurses. That same year, there were only 16,000 black physicians to serve the country's 22,000,000 blacks.

In response to the deteriorating health conditions of blacks in America and the continued strict segregation within the health care industry, Meharry was swept up by the inspired winds of the civil rights movement. Throughout the late 1950s and '60s, many Meharry medical students and faculty joined in the sit-ins, freedom rides, desegregation of health services and other civil rights demands. In 1966-67, a faculty renaissance occurred on the Meharry campus with the appointment of Dr. Lloyd Elam as college president. "It is ironic, yet appropriate," he said, "that out of a past stained by discrimination and poverty this college should emerge as a national leader in the movement to bring medical and technological excellence into an equitable balance with social needs."

During this same year, Dr. Elam helped to convince me to come and help realize the new Meharry "mission". Previously, I had worked with the United Mine Workers Welfare and Retirement Fund in north Appalachia developing a network of community health centers. My first autumn at Meharry was marked by a visit from Stokely Carmichael which resulted in racist counterattacks and severe police brutality, especially against blacks in the college and local community.

Dr. Elam withstood many pressures and pressed ahead with Meharry's commitment to innovation in both health service delivery and medical education. To combine this dual commitment, the faculty oversaw a far-reaching series of off-campus problem-solving learning experiences. Meharry students began to shift the focus of their educational experience by developing concrete community health projects throughout the South.

Community Medicine Leadership

In addition to the Neighborhood Health Center and an on-campus reorganization of clinics into a Comprehensive Health Center, medical students and housestaff also intiated other education efforts in the community. In Rossville, Tennessee, site of the famous "Tent City" during the '60s, Meharry and Vanderbilt students worked and lived in the black community, held health fairs, and helped to start the Poor People's Health Clinic. In Frostproof, Florida, Meharry students helped serve a family health plan for the migrant workers and their families. And in Philadelphia, Mississippi – right down the road from where civil rights workers Goodman, Schwerner and Cheney were murdered in 1964 – Meharry medical students and residents are working to support the Indian Health Service on the Choctaw Reservation. More recently, Meharry and Vanderbilt students and faculty have helped start an occupational health project with union members in the Nashville area. An outstanding consumer-sponsored community clinic, the Waverly-Belmont Clinic in Nashville, also relies on Meharry faculty and housestaff for its medical services. And the college provides prisoners' health services for jails around Nashville, and rural primary care services in ten counties through health department centers – an innovation for these predominantly white counties.

The Ongoing Struggle

While poverty, pollution, hypertension and cancer have been the lot of all too many people in these communities, Meharry itself has recently been plagued by serious financial problems. The institution's rapid growth has been necessary in order to survive and compete within the burgeoning Southern medical/industrial complex. Because of the school's sizable $30 million yearly budget, Meharry has been carrying an annual debt of $2-3 million, mainly due to hospital costs. A "cash crisis" occurred during 1977, which was mollified with federal education "distress grants" and emergency funds from HEW. Because the Vanderbilt medical center has a monopoly on funds and salaries from both the Nashville Veterans Administration hospital and the Nashville City-County Hospital, Meharry gets the short end of the city's financial stick, in spite of its excellent service to Nashville's medically indigent population. While this arrangement appears unfair, Vanderbilt's power depends in part on this economic dominance, which it will not relinquish willingly. Meharry is attempting to obtain regular, on-going special Federal monies by being designated a "national resource."

As an institution born, bred and nurtured in conflict, the key to Meharry's long life has been its ability to thrive, learn, and grow through struggles which constantly threaten its survival. After a century immersed in the struggle for justice, the question of Meharry's current involvement in supporting South African freedom fighters can be seen as another hopeful chapter in the life of one of our country's most innovative black education institutions.

As Dr. Elam remarked during Meharry's hundredth anniversary celebration, "There is a compelling obligation to conduct our programs in an atmosphere of self-criticism, hospitable to the clash of ideas in the never-ending quest for better results." □

We're way up in the mountains in a coal mining town. We started out by putting on a health fair with medical students from Vanderbilt University. We'd seen the need of the people in our community that had been forty years and not seen a doctor. We couldn't even believe that people had been that long without a doctor.

Then we organized a community health council and decided we'd build a clinic and see if we couldn't get some health care for our people. Before that, we had one doctor that was eighty-four years old and used to work for the coal companies. When we started we thought that everyone would help us and be for health care.

But in order to get our clinic, we had to get approved by the county judge which he hated, and the county medical society. We had to scheme and beg and plead and feel almost like we are committing crimes just to get what is really rightfully ours.

One pretty high-up official in the state health department said to me, "Mrs. Bradley, you're fighting against the system!" I said, "If you can look around and see that this system has ever been kind to us, then I'll quit right now!"

–Kate Bradley
Petros, Tennessee

by Kevin McDonald

Folks in some parts of Tennessee and Virginia call the Student Health Coalition (SHC) the greatest thing that ever came to town. In the same places, people can be found who say quite the opposite. And to some people outside those communities, the SHC is a mystery, a rumor carried by the wind.

Why the controversy and confusion about an organization that has made a creative contribution to community health care in many areas of Virginia and Tennessee? The answer comes slowly. The story of the Student Health Coalition is long and complicated, and parts of it are disputed. But it is an important story with implications for both medical education and community health.

The essence of that story involves the SHC's changing purposes, the changing times in which its blend of activism and community service took place, and the changing relations it had with various educational and financial institutions. Since its pilot project, the SHC has had three waves of activity. During 1970-71 the Vanderbilt and Meharry students invented the SHC; from 1972-74, a new generation of students institutionalized its more respectable methods and goals; and since 1975 the group has been groping for a new orientation.

In 1968, a handful of students and two faculty members at Vanderbilt Medical School created the original group, "Project Community Outreach, A Student Coalition in Community Health." Their brainstorming began in September, 1968, after a representative of the Josiah Macy

Kevin McDonald, who is a senior at Vanderbilt University, worked with the Appalachian Student Health Coalition in 1975, directed the Coalition in 1976, and served on the Board of Directors of the Center for Health Services from 1976-78.

Outreach and Outrage:
The Student Health Coalition

Foundation (of Macy's Department Store) called Dr. John Chapman, then dean of the Vanderbilt Medical School and invited him to send a student to Macy's conference on "The Changing Characteristics of Medical Students," to discuss the growing "threat" of students taking over medical schools. Dean Chapman chose Bill Dow, then a first-year medical student and the only one interested in attending. At its conference that September, the Macy Foundation offered to provide funding for projects which would help channel the growing student radicalism in the nation's medical schools back into the existing health care system.

After the conference, Dow returned to Nashville and met with fellow students and faculty. Standing out among those was Dr. Amos Christie, Professor of Pediatrics, who, with others, helped plan the first summer's activity. They discussed their ideas with students and faculty from Meharry Medical College across town, and in March submitted a grant proposal to Macy for $20,000. The newly created Student Health Coalition eventually received a grant of $9,600 "to investigate community health care problems and formulate possible solutions and methods of implementation and to bring about changes in the health science student's education so that it is more oriented to the total picture of the patient and his setting."

Several factors helped the students launch the Coalition. Although these were the days of student activism and protest, the New Left movement barely touched Vanderbilt University and missed the Medical School entirely; yet it did leave its mark on the campus in a number of student groups which had a distinct community orientation. The War on Poverty focused attention on the poor South, and private foundations bid to outdo the government in providing funds for social welfare programs. A handful of teachers and students at Meharry and Vanderbilt with some history of social action founded the SHC as a way to become involved in the larger social movement.

When the students set out to investigate health care problems in 1969, they wanted to establish "an ongoing organization encompassing the entire university community... which [could] make itself available to investigate community, regional, or national problems." But they had no organizational models to follow. Nor did they have a clear focus on a particular area of health care. Their original proposal suggested that "the institution of maternal and child care clinics, the reasons for and how to improve housing and rat control, and how to provide a more relevant health program in the public school curriculum, all are definite possibilities."

During the summer of '69, thirteen students did simple medical screening in Nashville and Williamson County, Tennessee, until August, when a few students and Dr. Christie went to east Tennessee, uninvited, to run a health fair in conjunction with the Presbyterian Church. At the health fair, a number of students took medical histories and did physical examinations of adults and children free of charge. According to Dr. Christie, "the whole trick of the thing was to make the medical screening process like a carnival that would be fun to go to." While participating in the Presbyterian health fair in Clairfield, Tennessee, the students were impressed by a local health council, an incorporated group made up of local citizens and chartered to develop health care facilities in the community. The students saw the health council, and its goal of creating a community-controlled primary health care center, as a model that needed encouragement and expansion in other communities. As Bill Dow described in a reference to the White Oak Health Council, "A health council...has taken on the task of canvassing the community and registering people for Medicaid. They are interested in building a clinic and we feel like their potentials are quite extensive if they can find assistance."

The students vowed to use the health fair – health council – community clinic model the following year. Janice Ambry, a volunteer nursing student wrote at the summer's end, "The encounter [with problems in the real world] has forced my commitment to action, to work for change in a situation inbred with economic prejudice and white racism. A situation which robs children of Tennessee – and America – of good health." Dow also made a sort of pledge: "I am extremely pessimistic with regard to the ability of the Public Health Department to meet its specified tasks, of the medical profession to meet up to its ethical and moral obligations of providing any, to say the least, good comprehensive health care for all, or the government's ability to provide this care....This is the area in which I see the greatest need and at present am moved to direct my career toward."

During 1970 and 1971, a core group of about thirty students from several disciplines led a larger group of 172 students on a drive to set up primary care centers throughout Tennessee. Under the supervision of physicians, Vanderbilt students operated health fairs for a week or two in ten communities. While these students took medical histories and gave physical examinations, usually in a school, other students helped organize local health councils. With health clinics as the focus around which poor people would organize themselves, members of the Coalition expected sweeping changes to occur rapidly. Some of them had read Regis Debray's *Revolution in the Revolution* for theoretical guidance, and now envisioned a mass takeover by "poor people of resources and institutions vital to them."

Sloppily, but enthusiastically, the students made visible progress. They cared little about administrative structure, and took pride in maintaining makeshift procedures for controlling finances and progress reports. They sat on the floor of Dr. Christie's office in the Vanderbilt Medical School and spent hours making simple decisions, but were excited about having involved so many people in the process. In 1970 and 1971 they operated seventeen health fairs and eight special projects related to health care, helped to organize seven health councils and to initiate six courses at Vanderbilt Medical School, and laid the foundation for the subsequent development of Vanderbilt's Center for Health Services.

Making the Coalition a project of the Vanderbilt Medical Center represented a radical departure from the University's traditional emphasis on research and drew hostility from many faculty members. Vanderbilt was known primarily for its excellence in specialization and had no interest in community involvement. After forty years, Vanderbilt proudly boasted that it had produced only two general practitioners. Accordingly, in 1971, when the students announced plans for a bigger and better program to promote community involvement in rural health care, many of the faculty scorned them and nicknamed the Coalition "Christie's Commies."

In contrast, the students' relations with the communities they served were quite good, especially with some of the less powerful citizens. Unlike their first fair in 1969, the students now entered communities only at the invitation of the local populace. They lived with them, held jamborees with them, and became their friends. During these years, the students looked to the local people for answers, and the local residents shared their way of living with pride.

Initial meetings were often intriguing to both students and community. Marie Cirillo, a Clairfield resident, recalls the first SHC health fair in 1969: "The people here were mystified by the whole thing. They crowded around the outside of the school house and watched the people go inside and later come out. Gradually they felt comfortable with it though, and liked it."

When the students first came to Petros, Tennessee, in 1970, Kate Bradley, a local resident, remembers feeling both curious and enthusiastic: "The students had a funny way of involving poor people, and they actually got more people involved than I thought they could, but gradually they gave us confidence in ourselves."

Members of the SHC recall the zeal with which they worked in those years. As John Davis, a former Coalition member, explains, "This was like our summer abroad, our contact with the real world...and we lived those days as if our lives were riding on the outcome."

Ups and Downs

Throughout the summer of 1970, many of the students disagreed with each other on specific solutions to problems in organizing and working with the community groups, but they thrived on this conflict. They were learning to develop new and better health care systems and spoke excitedly of their discoveries. Said one student, "Most of us have a better understanding of the politics of medicine....None of us will be able to remain in Vanderbilt Hospital, or our private offices, satisfied that we are doing all that a physician should do." Another student comments, "The project has taught us much. Nurse practitioners and other paramedical personnel can and should be utilized to relieve the medical care problem. A doctor's training should include experience with community medicine."

After the summer of 1970, many students felt confident, even relieved, that they had demonstrated their ability to bring about change. The law students commented, "We gave people a better understanding of young Americans today and their concern for the poor and their dislike for the inequalities of the system." Muffy Ecker wrote of her experience in Smithville, Tenn., "The project has proven to me and others not only that students can handle real responsiblity, but that they need to if college and/or professional education is to be of value. It still seems early to evaluate the long term effects of the project on the medical establishment, but it is exciting to me to see the potential begin to be realized of poor people in those communities to speak and act for themselves and begin to get what they really need on their own."

By August of 1971, however, many students began to dislike and criticize what they had done, as their practical experiences in the Coalition failed to measure up to their New Left political ideals. One faction, dominated by medical students, believed that the Coalition was basically good and should continue unchanged. To them, providing health care was an end in itself, and the SHC was helping local people achieve better health services.

The other faction, led by community organizers and students outside the medical school, had decided that the SHC was an inadequate medical means to a revolutionary political end. Students in this group believed that the SHC had, in most cases, imposed health care as a priority on people who had more pressing needs. If health care had functioned as a catalyst for organizing around broader issues, these students might have been satisfied with the Coalition's past activities. But they saw the health councils which they'd built as "medical PTAs" which were bogged down by administrative requirements and procedures.

The radical students didn't believe that building small community institutions would catalyze people into demanding sweeping reforms and revolution. The clinics, which the SHC had helped to initiate, might temporarily disrupt local professional and political arrangements, but in due course they would run out of money and expertise, forcing the health councils to surrender their autonomy and be swallowed by the system. The more moderate students still believed that slow, methodical organizing would be necessary for implementing significant social change. The radical students responded by declaring that the Coalition should not become an established, respectable institution capable of slow, long-term building, because it would be unable to fight other establishment structures.

After this conflict, most of the more radical students left the Student Health Coalition. They departed, however, as decidedly different people than when they had first come to work with the Coalition. Many had finally acquired the practical experience that they had longed for in their early college years. Several secured jobs in Appalachia in which they could continue their commitment to broad-based social change. Others pursued traditional careers, but with an idealism they had tested, found useful, and learned to apply.

In place of these students a smaller group, with some carry-overs from the previous Coalition, began to turn the SHC into the more respectable institution which the earlier students had feared and scorned. With the Coalition's budget now around $100,000 a year, funding sources and the university administration were also looking for a more stable and accountable institutional structure. To meet the growing need for respectability and long-term survival, coalition leaders organized the Center for Health Services as an umbrella organization to do fund-raising, activity planning, and provide technical consulting to community clinics – and thus become the institutionalization of earlier Coalition efforts. The Center received an old building on campus, developed its own staff, many of whom were former Coalition activists, and began advising the ongoing SHC programs.

The members of the 1972-73 Coalition inherited from their predecessors the dispute about whether health care was to be the sole focus or just a means to a broader political end. The medical goal continued to be health fairs and primary care clinics, but the political goal was harder to articulate. Gradually, the students realized "that the most important contribution they could make lay in the area of community development," and their decision to pursue this shaped the SHC for the next three years.

As the central project of the Center for Health Services, the Coalition helped map out a plan for long-term institutional change in the health care system. The students began to read Harry Caudill's *Night Comes to the Cumberlands* and Si Kahn's *How People Get Power*, quite a switch from *Revolution in the Revolution.* They streamlined their projects to serve fewer communities better with fewer students. As one Coalition member explained, "In 1971, the health fair visited nine communities. It was an exhausting experience. Long-term change in each community requires a concentrated effort. So, the decision was made to visit fewer communities this year."

"Vanderbilt proudly boasted that it had produced only two general practitioners. Accordingly, in 1971, when the students announced plans for expanding their involvement in community health programs, many of the faculty scorned them and nicknamed them Christie's Commies."

An event in September of 1972, when the new group of students was still consolidating, sharply illustrated the difference between the old and new students. Tricia Nixon, campaigning for her father's re-election in 1972, visited the Center for Health Services. The new Coalition members were eager to meet with Ms. Nixon and discuss the urgent health problems of Appalachia. Some of the older graduates from the 1970-71 SHC heard about the Nixon visit and considered it the last straw, the final sell-out by the SHC to the Establishment. They returned to Nashville for the occasion, protested the meeting with signs ("Nixon Wants Votes, Not Health Care") and demonstrated in front of the Center, which they had previously scorned.

Their leaflets claimed the Coalition's methods consisted of "raising false expectations for long range medical care and then shattering those expectations." They implied that the SHC was really a device for students to improve their own education at the expense of Appalachians. The leaflets also criticized the project as a ploy by the university to raise its own funds and to recruit students. It derided the Coalition for betraying its original "self-consciously anti-medical establishment attitudes."

In defense of the SHC and its sponsorship of Nixon's visit, Rick Davidson wrote a letter to the *Vanderbilt Hustler*, the student newspaper. According to Davidson, the protesters had "all worked in areas which we considered total failures," proof that their criticism was invalid since the SHC had "proved effective in other communities where...the community workers were more intent on improving health care delivery, and less worried about organization for organization's sake." Davidson concluded his letter by comparing the protesters to the Nixon Administration: "It seems that the 'protesters' are no better than the Nixon administration as far as concrete proposals; neither group can get its mind off rhetoric long enough to come up with suggestions."

The "respectable" Coalitions from 1972-74 were indeed concrete and productive. They organized seven health councils and a chapter of the Black Lung Association. They did useful studies on the financial structure of the pallet factory in Clairfield, taxation in a five-county coal-mining area, and designs for medical buildings. Many of these tasks were clearly in the old tradition, while others were the outcome of previous efforts to organize health councils.

The SHC students in this second generation took a different approach, one which stressed technical expertise, planning and feasibility. They seemed to talk more and listen less but were interested in getting things done and improving their methods of solving practical problems like keeping medical records, conducting efficient health fairs and facilitating fundraising for clinics and community organizations. Accordingly, their year-end recommendations dealt mainly with the development of their own techniques. For example: "The entire question of supplies from the public health department needs to be reviewed in order to avoid mixup in the future." "The special projects students should not live in one central place but should live in as many communities as possible." "More time should be incorporated for follow-up either at the end of the summer or

within the health fairs."

The students did succeed in improving their methods, but they suffered from a high turnover in personnel each year. Emphasis on expertise and feasibility, they slowly discovered, led to depersonalization of the work. A danger of the students' consequent preoccupation with technical expertise and bureaucracy was their tendency to overlook crucial aspects of clinic development and community organizing, especially local leadership training and community education. As

"In place of these students, a smaller group with some carry-overs from the previous Coalition began to turn the SHC into the more respectable institution which many of the earlier students feared and scorned."

The widespread enthusiasm of earlier days was gone. Individual participants no longer had to commit themselves to local community people – since they believed the Center for Health Services would continue to maintain relationships with local projects that transcended the role of individual students. People plugged into specific tasks but did not understand that the overall project and the Center needed them to work for more than a summer; nor was there a larger social movement to educate them about how power works or motivate them to make greater commitments to social change. Statistics on participation reveal this trend, as student activism at Vanderbilt and around the country waned. Aside from project directors, only six of the fifty-six students from the 1972 Coalition returned in 1973, and only five of the forty students from the 1973 group returned in 1974.

One consequence of this high turnover was centralization of the SHC and development of a burdensome management that often fell on the shoulders of just one or two students. Bob Hartman, sole director of the 1973 East Tennessee Project, expressed his frustration when he wrote, "The directorship drastically needs to be split among several students with as many former workers as possible trying to pass on their experience to some of the new folks."

Because of the increasing complexities of the health care bureaucracy and funding requirements, the students became engulfed in red tape and professional jargon. To complicate the situation, some doctors, lawyers and administrators in the Center for Health Services and the East Tennessee Research Corporation, many of them veterans of the SHC, began to echo the foundations' and government's demands for fiscal feasibility. financial problems increased for the original SHC-inspired clinics, internal strife heightened within the clinics, and administrative and professional staffs, many of them SHC veterans, began to clash with local health councils over new directions and policies. As problems became more tedious and complicated, the Center seemed less able to channel the energy of students into productive and experimental projects, as the SHC had done in the past. More and more of the program became wrapped up in solving technical problems connected with the survival of existing councils and clinics, and less and less in putting students into the field in creative ways.

In spite of these roadblocks, the students operated the Coalition machinery well enough to organize four new health councils during 1974, but SHC leaders expressed anxiety about the future. Private foundations no longer considered the students' work as legitimate and hesitated to fund the Coalition's activities.

Cutbacks

In 1975-76, several factors sent a third generation of students into a tailspin. The economic crunch of 1973 had caught up with funding sources, which reduced their budgets for both clinics and student projects. In addition, grant money that used to come directly to the SHC, to use as it saw fit, was now channeled through the Center for Health Services, which put increasing restrictions on the students to develop successful "financially feasible" clinics. The SHC and the Center clashed particularly over the issue of selecting communities for the summer projects. In the past, the Coalition members had been free to go wherever they were invited and set up a health fair. Now, the students were being told that they could not hold health fairs wherever they were invited – by the same people on the Center staff who a few years earlier had roamed the state freely holding fairs and setting up clinics.

The student leaders also began to have difficulties in recruiting participants for the summer's work. The days when activism was popular had passed and current students wanted simple tasks that they could easily perform. The drying up of both funds and student participation distracted and disrupted the model of clinic development that the Coalition had previously employed. The Coalition's resulting preoccupation with fundraising has meant that there is less time to look for communities to work with to involve energetic students, and to develop effective methods of community follow-up.

In spite of these difficulties, a small group of dedicated students has tried to continue the health fair/community clinic model, while simultaneously developing projects in occupational health with copper miners, local Health Systems Agencies (HSA) activities, and doing flood control research. As always, the Student Health Coalition continues to hammer out its new identity as each year's students and community participants determine the scope, content and vigor of the Coalition's activities.

Meanwhile, the Center for Health Services has expanded its role as an umbrella for a variety of service programs, including rural legal aid, agricultural marketing, legislative research, and technical assistance to clinics. Its budget has dramatically increased, while the SHC's has dropped. A glance back through the Student Health Coalition's decade-long history reveals one of the country's most successful and productive student-controlled community health projects. Involving over six hundred Vanderbilt and other students in its activities through the years, the Coalition has worked in over thirty communities throughout Tennessee and Virginia and helped to initiate more than ten primary health care clinics. The Coalition grew and flourished during the heyday of the student movement of the 1960s, when there was an abundance both of money for innovation and idealistic students with boundless reservoirs of energy. In spite of the slackening of student activism and disinterest by funding sources, the

Coalition has bravely tried to continue its health reform efforts in a more institutionalized and scaled down way.

If there is a message in this story for colleges, the government and foundations, it is this: that students, if given the resources, the responsibilities and the freedoms can achieve constructive social change in the health care system. For students, the message may be conversely: if students in community health projects want to ensure their usefulness and freedom to experiment, then they should maintain some authority in their relations with outside experts and funding sources.

Even more important than the Coalition's projects and activities over the years are the students who threw themselves headlong into its activities, inspired by the vision of community-controlled health care delivery. As the students' eyes were opened to the politics of medicine in rural America, they, too, were changed. Many of them have gone on to staff clinics across the South that they themselves had worked to initiate. They work on day to day, still carrying the original vision of the early Coalition era.

Ironically, the Coalition began as a project of the Macy Foundation to stem the growing radicalism in medical schools and to coopt increasing student attempts to take control of medical education. On the Vanderbilt campus, the Macy money had the completely opposite effect. It helped to produce a generation of students with high ideals and practical experience in changing both the medical education process and the health care delivery system.

That student activity produced a generation of people (1970-71) with high ideals for social change. Upon graduation from Vanderbilt members of that generation applied these ideals in different forms, some becoming health professionals within the formula they had helped to invent. Those interested in community development passed on their formula to a second generation (1972-74) of students that became even more productive with it than the first generation had been. But after funding sources lost interest in financing student and community projects, members of these generations constrained a third generation (1975-77) of students. They took the position of funding sources and through the Center for Health Services, allied themselves with the University they had once fought against. Thus in a sense, money fostered a radicalism and then, through the agents of that radicalism, constrained it once again.□

Dr. Amos Christie, on motorcycle, earned the scorn of the faculty and the Coalition was dubbed "Christie's Commies" in 1971.

Oliver Harvey
"Got to take some risks"

Drawing by Janet Beyer

At Duke University, workers in the medical center have fought for over twenty years to win a union against overwhelming opposition. The huge hospital-research-medical school complex employs some 10,500 people and is the city of Durham's largest employer. It is impossible to understand the organizing campaign at Duke without knowing something about Oliver Harvey, the slight 5'5" black janitor who kept the fires of unionism smoldering through the long, lonely years of apathy and fear.

by Ed McConville

Mr. Harvey, as he is affectionately known to the younger workers at Duke University's sprawling medical center, grew up on a farm in Franklinton, a tiny North Carolina textile and tobacco town. Oliver Harvey's father was one of the few black farmers in the area to own his own land, and he lost it in 1933 in a manner that made a lasting impression on his son. "He had tenants and he encouraged them to save up and buy their own farms," said Harvey. "That way nobody could tell you you had to move on, 'cause it was your own. He always tried to help them.

"Then, right at harvest time, they stole off in the middle of the night with his cotton and tobacco, and that was the last we saw of them. They sold the crop and run off. He came up short with the bank and lost his land. He would be as fair as he could to people, and then be surprised when they weren't fair to him. That's what carried him down."

Unwilling to settle for sharecropping himself, Harvey came to Durham looking for work. After going through a number of temporary menial jobs, he considered himself lucky to land a "real job" at the American Tobacco Company in 1936. The tobacco workers union was mounting a successful organizing drive there at the time – on a segregated basis. One local for whites, one local for blacks. "When they tried to organize me, I told them I thought a union would be very instrumental to the people working there," said Harvey. (An utter pragmatist, he uses the word "instrumental" frequently.) "But as far as the separate locals went, I said, 'I don't know anything about unions, but I don't like that. We're always Jim Crowed outside the union, so why should we have to join different organizations inside it?' 'That's just the way it is,' they said. I said, 'The word "union" means together.' They said integration was against the rules of the international, and that it would be detrimental to their organizing efforts. I said I was sorry, but I couldn't join their union.

"I got my hatred for segregation from my father," explained Harvey. "He was raised up in the house of a white couple, two liberal lawyers. He learned to always speak up for himself."

Harvey inherited the habit, which proved to be an occasional source of difficulty. After refusing to join the union, his boss called him into the office and asked him where he was from. "He was surprised when I said 'North Carolina,'" recalled Harvey. "He said, 'But you've got Northern ideas. Black people are free up there.' I said, 'These aren't *Northern* ideas. I been up there and there's racism there, too. It's just not as wide-open, as plain, as it is here and in the states around.'" Not surprisingly, Harvey was the victim of a one-person "layoff" about two weeks later.

He then went to work as an orderly at Watts Hospital in Durham. High turnover and its correlate, lack of job security, have always plagued unorganized hospital workers, and Watts was no exception. "Any black who spoke out there, who wouldn't take their driving, was in danger of losing his job. Any time you talked

---

Ed McConville is a free-lance writer who has also worked in the South as a union and community organizer. He is at present writing a book on the struggle to organize J. P. Stevens Company.

back to a white, you were 'sassing.' Boy, I hated that word. It really did something to me. I asked them, "Why can't one adult defend himself in front of another?'"

Although Harvey's experience at American Tobacco had not made him any less outspoken, it had made him more cunning. "The only thing that saved my job was blackmail," he said. "I always had something on everybody that ever tried to fire me. Helping themselves to the goodies in the medicine cabinet was a big thing there. Doctors and nurses drug-abusing saved my job I don't know how many times. Or the charge nurse would send a student nurse into the medicine cabinet, which was against the law. Those student nurses would give people the wrong medicines all the time.

"I had to find a way to speak out on the job," said Harvey. "You can't work scared, cause you can't produce when you work in fear."

He also created quite a stir when he went to work for the unionized Kruegur Bottling Company in 1943. Kruegur, Durham's highest paying industrial employer, was forced to hire blacks during the wartime manpower shortage. But they were shunted into a separate local and paid substantially less than whites working on the same machines. Harvey convinced the blacks to stop paying union dues. "The [union's] area director came in and things got pretty hot between us," he recalled. "Finally he gave in and disbanded the black local and put us all in together. That was the first integrated local I ever heard of around here.

"But that was just problem Number One," he said. "Our pay scales were still segregated." So Harvey led the blacks out on a successful wildcat strike well before the union's contract expired.

"What happened next really surprised me," he said. "Forty-four of the forty-five whites in the plant came running out after us. It really frightened me, because there were some very racist people there. I said to the other pickets, 'Look out people, now we got to fight like the devil!' I was sure those people had come out to attack us, but they had come out to join us. All of them didn't agree with the way we were being treated; I had never suspected that. I learned you should never close the door on people, always give them a chance to do the right thing."

A moment of comic relief came when Harvey called Kruegur's president in Newark, New Jersey. "Are you colored or white?" asked the man's secretary before allowing that her boss "might" return his call. That night Harvey answered his phone at home to hear the industrialist ask in a tentative tone whether he might speak with "Mr. Harvey."

"First time I ever heard a white man call me 'Mister,'" he chuckled.

Having scaled such giddy heights of social equality, Harvey was ill-prepared for the gothic gloom of Duke University. After trying unsuccessfully to run his own restaurant, he went to work at Duke as a janitor in 1951 at the age of forty-two. "We were supposed to call all the students 'Mister' and 'Miss' in those days," he said. "The president of the fraternity where I worked at the time was from a wealthy family. One day he said, 'Good morning' in a friendly way, so I said, 'Good morning, Ed.' He just stared at me. The maids all said I would get in trouble if he told our supervisor. I couldn't believe he could be that concerned; he was a student and I was at least twice his age. But sure enough, when he got back from class, he said he'd like to have a talk with me. 'I thought you were supposed to call us 'Mister,' he said. 'Why did you call me 'Ed' this morning?'

"I said, 'Why do you ask me that, Ed? Does it really bother you?' He got all embarrassed, so I kept on. 'If you don't like it, tell me,' I said.

"'You're right,' he said. 'It's stupid. Tell all the maids to start calling us by our first names, too.'"

Duke's insistence on antiquated forms of address from its employees was symbolic of the university's paternalistic, almost feudal approach to labor relations. A seasoned shop steward by this time, Harvey was quick to see that a different set of power relationships existed there than in private industry in Durham, which is one of the most heavily organized cities in the South. "Working in a factory," he said, "you can strike and stop management's money from coming in. A university is different. It doesn't produce a product you can hold in your hands. It can run a long time without its workers."

Duke was not above taking advantage of the situation. "In addition to low wages," recalled Harvey, "we had hardly any fringe benefits at all. No holidays, no sick leave. You got sick, you starved, cause you only got paid for the days you worked, no matter what.

"I realized then that it would be at least fifteen years before workers there were ready for a union. They were too scared and ignorant. There's a season for things. Like when the government and industry needed people to work in defense plants in World War II, they had to let a lot of unions in. But it

photos courtesy of the Duke Chronicle

Oliver Harvey addresses students, faculty and workers during 1968 strike at Duke University.

Photo by Jackson Hill

Over the years, different unions have attempted to organize the hospital workers at Duke. Pictured below is a rally held by 1199 during an unsuccessful organizing drive in the early 1970s. The only Duke employees now represented by unions are the campus service workers (AFSCME) and maintenance workers (IUOE).

wasn't the right season at Duke yet.

"I hated working there, the way they treated you, but I hung on for all those years when nothing was happening because I wanted to learn. I talked to students and faculty whenever I could. They loaned me books. That's how I got my college education." (One of his favorite books is C. Vann Woodward's *The Strange Career of Jim Crow*, and one of his favorite subjects, the problems and possibilities inherent in forging alliances between black and white activists.) "I taught the students a lot, too," he said. "They were surprised when I told them that civil rights organizations like the local NAACP and the Durham Committee on Negro Affairs (DCNA) wouldn't help hospital workers at Duke, because they were run by black businessmen from Mechanics and Farmers Bank and the North Carolina Mutual Life Insurance Company who treated their own black employees just as badly."

But the solace of philosophy was not the only thing that kept Harvey going during the 1950s and early '60s. He circulated petitions every few years demanding better conditions in the medical center and on the campus. "There weren't but nine people would sign the first one in 1952," he said. "They were sure it would cost them their jobs. I said, 'We've got to take some risks if we're ever going to do anything. Life is a risk. Don't just worry about your own job, worry about what that job will be like for your children. Doing something for somebody else is the only way to better your own conditions in the long run.'"

The number willing to sign the petitions increased every time they were circulated, but Harvey eventually had to stop. "The personnel office was giving the people who signed them secret wage increases and promotions to keep them quiet in the future. They offered me pretty much whatever I wanted to stop raising sin, but I didn't want anything they had to offer. All these years Duke has always tried to divide people against themselves. They created separate pay classifications for the same jobs, like Janitor I, Janitor II, and Janitor III. That's a lot of crap. There's no I, II, and III. If you're a janitor, you're a janitor, that's all. The biggest fool in town can come in and clean up.

"In the hospital," he continued, "all nurse's aides were white and all nurse's maids were black. They did the same work, but nurse's aides were much better paid. They'd try to pit us against the white workers. When the union came around, they'd tell the whites, 'That's an all-black organization.' And they'd tell us, 'You don't need a union; we'll give you a little raise, more than your co-worker next to you is getting. But don't tell him or he'll want one, too.'"

Working conditions in the health care industry are among the worst in our economy. "One of the hardest things about hospital work," says union organizer Kim Pittman, "is that you're dealing with people, not products. It beats the hell out of your emotions. One day you're feeding some little kid, getting involved with him, and the next day they've got you carrying his body out. Most hospital workers aren't sophisticated enough to be clinical and detached like doctors. And it's just a rotten job at a more basic level; you're cleaning up people's wastes and their blood all the time."

Another problem, says Pittman, who is currently organizing workers at Duke University Medical Center for the American Federation of State,

County, and Municipal Employees (AFSCME), is that "doctors are like gods in the medical hierarchy. They'll go to your supervisor and tell him they didn't like the way you said hello that day; you can catch hell for a little thing like that. And they've got too much ego to ever admit they could make a mistake, so the worker at the bottom of the pecking order often gets blamed when things go wrong."

Two other hospital union officials, who have also organized in the textile and automobile industries, agreed that, in the words of one, "Of all the management types I've ever run up against, doctors are by far the worst in terms of sheer arrogance." The exasperated administrator of a United Mine Workers clinic in Appalachia was even more categorical. "Before you can even begin to understand the health care industry," he once told me, "you have to grasp one basic fact: doctors are bastards, absolutely and without qualification. The hell with national health insurance, the biggest problem in American health care today is the physician ego!"

It must also be said, however, that hospital administrators, in their frustration with physicians whom they cannot question too openly, often take their wrath out on innocent employees.

Health care institutions use their employees' guilt to fight unions. "Hospitals," says Pittman, "try to brainwash their employees into believing there's an inevitable conflict between bettering their own conditions and providing good care to their patients. But, realistically, well-respected workers with good morale give the best care."

Pittman says Duke's "priorities," like those of most hospitals, "are screwed up. Every time some big-time medical center up North gets a new million-dollar piece of equipment, they've got to have one just like it. But they scream 'irresponsible' every time their workers ask for higher wages."

Duke's image in Durham also makes it tough to organize, he says. "The guy who works at Liggett & Myers makes more than many of these health care professionals here, but they feel they have more prestige in the community because they work at Duke."

Hospital organizing took years to come to a head at Duke. While he spent most of his time in the 1960s explaining unions to maids, janitors, food service workers, and "patient care attendants" in the medical center, Harvey also became deeply involved in the civil rights movement. When the Greensboro lunch-counter sit-ins spread to Durham in 1960, some North Carolina College (now NC Central University) students asked Harvey, then past fifty, to join them in a foray against Rose's downtown department store. "I didn't say yes or no," he recalled, "because I could see the police waiting for us. But then I said to myself, 'These students are afraid, too, but there they go.' So I went in with them. We were snatched away from the counter and arrested as soon as we sat down.

"I really learned a lot about organizing in the civil rights movement," he said. "I went down to Martin Luther King, Jr.'s hotel room when he came to Durham to ask his advice about Duke. I told him I was like Mrs. [Rosa] Parks on the bus in Montgomery, that I needed an educated person like him to be my leader. He said, 'Wait a minute, now. People like me can help you, but we can't organize Duke for you. The only ones who can do that are the people who work there. I can help you write up a set of demands, but only with the inside information on working conditions you provide me with. A lawyer can give you legal advice, but only after you document the day-to-day facts for him and tell him what you want to change.'

"We done rocked the boat," Harvey said. "Now let's stop it."

"Dr. King told me I was on the right track, working with unions, and said he was going to move on to economics himself after he was done with civil rights. He said I was ahead of him in what I was doing, that he had a lot of catching up to do. He gave me great encouragement. I said to myself, 'The waiting season is over. It's time to join up with some expertise and start a union.' "

Where once he sought out liberal arts students for philosophical discussions of social inequities, Harvey now began looking for those with technical knowledge useful in organizing. A friend who worked as a janitor in Duke's Law School building introduced him to law students who researched labor law for him and wrote most of his leaflets, letters, and

Hospital Labor Law

The American health care industry, North and South, pursues a labor relations policy that parallels that of the Southern textile industry. "The hospital industry is as vicious and anti-union as they come," said Daniel H. Pollitt, Kenan Professor of Law at the University of North Carolina who has served as special counsel to the House Subcommittee on Labor-Management Relations in Washington. "Hospital boards tend to be filled by the wives of wealthy industrialists who don't want unions in their own plants, so they're not going to let one into the local hospital at any cost."

Until 1974, all workers in private, non-profit hospitals like Duke — some 1.5 million people — were denied the protections of the National Labor Relations Act. This meant they could be legally fired or harassed simply for supporting a union, and had no legal right to vote for or against union representation.

Hospital workers' greatest problem seems to be lack of job security. "If those people get a cold they get fired so their germs won't spread," said Pollitt. "Paying Blue Cross and other fringe benefits for them would cost too much; it's much easier to get rid of them."

By August, 1974, even Rep. John Ashbrook (R-Ohio), leader of the ideological conservatives in Congress and a consistent foe of labor law reform, supported the bill bringing these workers under the Act's protection. Ashbrook went to Johns Hopkins University Medical Center for an annual check-up and was appalled by conditions for workers and patients alike. Finding a turnover rate close to 1,000 percent and "employees who didn't even know where to empty the bedpans," he concluded that something had to be done. The amendments, supported by unlikely allies like Sen. Robert Taft, Jr. (R-Ohio), passed overwhelmingly. □

demands. He called a mass meeting in early 1965 to form the Duke University Employees Benevolent Society, a transitional organization to give skeptical workers some exposure to collective action while Harvey and his law students searched for an international union to provide them with strike funds and expertise in organizing and bargaining. After rejecting several unions for what he considered their racism, Harvey convinced AFSCME, one of the few internationals willing to work with civil rights activists in the mid-'60s, to commit themselves to an organizing campaign at Duke in September of 1965.

"Duke tried hard to get rid of me from that time on," he said. "Most people get sleepy working on the third shift. They knew I was tired from running around organizing all day, and hoped they could catch me dozing and fire me. But I couldn't have slept if I wanted to; I had too many things on my mind. I got ulcers for the first time then. They drove me, stayed in close behind me all the time. I had to cross every *t* and dot every *i*, or I would have been gone. It was rough. God was the only thing that kept me together through those days."

After a spontaneous two-day walkout in the medical center proved partially successful, a full-fledged strike was planned in 1968, for union recognition and a minimum starting wage of $1.60 an hour. "We done rocked the boat," Harvey said. "Now let's stop it." Originally planned for May, the strike was moved up to the end of the first week in April when word of it leaked out and pro-union leaders became concerned that "people might peak too soon." Their strategy committee was meeting that Thursday to work out last minute details when they got word that Martin Luther King had been shot in Memphis. "This is it," said Harvey. "How much more do they think we can take?"

"We had in mind to invade the [university] president's house and take it over," he said. "The student government didn't want to, because they were afraid they'd get teargassed. But Dr. King's death changed their minds." Duke students kept an all-night vigil the Friday after the assassination. "I was in a new world the next day when I saw thousands of people protesting on the quadrangle," said Harvey. "It looked like one of Billy Graham's crusades. I'd never seen anything like it before, and I probably never will again."

But sympathetic students and faculty faltered in their commitment as the strike wore on. "I spoke to a packed auditorium," remembered Harvey, "and said, 'You said you wanted to help us, and we told you it would be rough. If it's too tough for you, we'll have to do it ourselves.' That really stirred them up, and I kept going. It was raining hard outside and some of them were complaining about how wet they got coming to the meeting. I told them, 'We were born outside in the rain. If it's too wet for you, go home and just get involved when the sun is shining.' "

Students and faculty contributed over $10,000 during the thirteen-day strike, says Harvey, with another $7,000 coming from the larger Durham community. But as the strike reached its tenth day, he could feel his own people wavering. "They were getting ready to go back to work," he said, "and I had almost given up. I knew we'd have to compromise more than we wanted to. But I kept up a bold front. The Duke administration asked me, 'How long can your people survive?' I said, 'You think you can starve us to death? Man, we been hungry 300 years.'

"But I knew I couldn't bluff much longer. They offered us an 'Employees Council' instead of a union. I knew it would be a company outfit, but I thought we could get Duke to hang themselves again and put us in a real union, which is just what happened. I told the people, 'Better we use this stick than none at all.' "

A white organizer tried to convince Harvey to hold out for genuine union recognition. " 'You don't know black people like I do,' I told him. 'These people are going *back* and there's nothing we can do about it.' He said we could use the students to bring pressure on the trustees. 'You must be kidding,' I said. 'These students want to graduate; they can't stay here forever.' He told me I should stay out as an example to other workers. I said, 'It's come time for me to look after just one group of people at Duke University. That's my wife and her husband.' "

Harvey's life has been marked by a constant tension between his drive to help working people and his need to do what he has had to do to survive. Some began to question his leadership after the strike. Internal union politics were rent with recrimination and factionalism. Embittered, he did something in the early 1970s that he had sworn to himself he would never do.

He took a supervisor's job.

"Most people aren't very grateful for what you do for them," he said. "I began to wonder whether I should make so many sacrifices and work so hard for nothing in return. People don't miss you 'til you die or move away; Martin Luther King's death proved that. I wasn't about to die to suit them, so I moved on out of the union."

But Harvey's deep regret over leaving the union is apparent when he speaks. Shortly after Duke's campus workers won union recognition in a landslide NLRB election in 1972, he reached retirement age and began devoting most of his time to organizing without pay in the medical center. He expended incredible energy trying to soften the intense factionalism which doomed the union to a surprisingly narrow defeat in a 1976 representation election in the hospital. After considerable persuasion by the union's rank-and-file organizing committee, he consented in early 1978 to go to work for AFSCME as a full-time paid organizer in the medical center.

He asked to be taken off the payroll after a month's efforts convinced him that the international's highly centralized organizing department in Washington, DC, was insensitive to the particularities of the local situation at Duke. He continues to work with the union in organizing the hospital, but feels his unpaid status leaves him freer to function as a loyal critic of their strategic mistakes. "The workers in the medical center need a union worse than anything," he says, "but I've learned that you can't just sit back and expect your international to do all the work and make all the decisions for you. An international is only as good and as responsive as the local people make it be."

As Harvey approaches the eighth decade of his life, he continues working and fighting for what he believed in as a young man in his twenties, combining the wisdom and experience of age with the outrage and idealism of youth. □

Cotton Dust Kills, And It's Killing Me

By Mimi Conway, Photographs by Earl Dotter

When a hand truck filled with yarn smashed Jesse Hawkins' rib last year, his employer, J.P. Stevens & Co., did not even send him to the doctor. The fifty-five-year-old black man had to go on his own. Hawkins' personal physician, Dr. R. E. Frazier, was also designated by J.P. Stevens to examine any of its Roanoke Rapids workers hurt on the job.

Dr. Frazier told Hawkins to wear a ladies' girdle and wrote him a medical slip saying he could do a full day's work. Hawkins, who was spitting up blood,

Jesse Hawkins

went to the local hospital for an x-ray. The results were sent to Dr. Frazier who told Hawkins, "Jesse, I'm glad you didn't have a broken rib. Go back to work. Tough it out as best you can."

Hawkins, still coughing up blood and getting no satisfaction from either his doctor or the company, stopped by the local union office of the Amalgamated Clothing and Textile Workers Union. The union made an appointment for Hawkins at Duke University Medical Center, where doctors found Jesse Hawkins had a broken upper rib and bone cancer. "At J. P. Stevens, they put people back to work that is sick and they know that they're sick," Hawkins said. "If you can't do nothing but sit around, they let you sit around

to keep from paying compensation. And all Dr. Frazier was interested in was that big sign they have outside the mill saying 'three million man-hours with no lost-time accident.'"

In terms of cost to the company, accidents such as Hawkins' represent miniscule outlays of cash compared with the costs of occupation disease. Both J. P. Stevens and its workers' compensation carrier, Liberty Mutual Insurance Company, know the bald statistics: the average occupational disease case is fifty percent more expensive than the average accident case.

Jesse Hawkins is filing a claim against Stevens and Liberty Mutual to get workers' compensation for his broken rib. He is filing another claim as well, for Jesse Hawkins has only fifty-nine percent of his breathing capacity. Hawkins has the classic symptoms of byssinosis or brown lung, a disease caused by excessive exposure to cotton dust, a crippling respiratory illness that has stricken some 35,000 cotton mill workers.

Most Wednesday afternoons, when weekly meetings take place, Jesse Hawkins can be found at the sunny offices of the Roanoke Rapids chapter of the Carolina Brown Lung Association. In joining the CBLA, Jesse Hawkins has joined forces with other disabled mill workers in the organization's three-year-old fight to clean up the mills and win compensation for workers disabled with brown lung. The CBLA has ten chapters in North and South Carolina.

One of them is in Erwin, North Carolina, "the denim capital of the world," where nearly everyone in town has worked in the giant red brick Burlington mill that spews America's favorite cloth round the clock.

The Erwin mill, the largest single maker of denim, also produces a lot of brown lung victims. By Burlington Industries' own count, 141 workers in this mill had the classic symptoms of byssinosis in 1971. In a company-wide survey that year, Burlington found that 460 workers in 19 Burlington-owned mills had symptoms of the disease.

The Denim Capital of the World

Unlike J. P. Stevens, which is the target of a nationwide consumer boycott because of its anti-union, anti-worker policies and practices, Burlington Industries leads the textile industry not only in profits but in reputation. Burlington is particularly proud of its medical surveillance program, instituted in December, 1970, after Dr. Harold ("Bud") Imbus came to Burlington to head its medical department. No other textile company has come close to Burlington in studying byssinosis among its workers.

Burlington built its public image as a combatter of byssinosis largely on its 1971 study of 10,133 employees exposed to cotton dust. The Burlington study established that 18 percent of the 1,266 workers in the preparation departments, the dustiest mill areas, had "classic byssinosis symptoms." The study also showed that 4.5 percent of all the workers tested had byssinosis. A 1976 Burlington study, according to Dr. Imbus, showed that out of a sample of 12,519 employees, 1.09 percent had byssinosis. Dr. Imbus explained the reduction: "A number of employees have been compensated, a number have left and a number who had the symptoms have been transferred." He also accounted for the drop by saying, "the number who have the symptoms has gone down, quite simply because of a lowering of the dust levels."

Some of the Burlington employees examined by Dr. Imbus in his 1971 study think the issue is not that simple. One is Linnie Mae Bass.

On April 26, 1977, the second anniversary of the CBLA, Linnie Mae Bass, president of the Erwin CBLA chapter, and a delegation of fifty CBLA members traveled to Washington, DC, to testify at public hearings held by the Department of Labor's Occupational Safety and Health Administration (OSHA) on the proposed cotton dust standard.

As the phalanx of old and disabled mill workers began their slow procession to the witness table, cameras whirred and ranged over the lined faces, the two wheelchairs, the denim overalls, the respirator, the two oxygen tanks. And still cameras snapped at the buttons each member of the delegation wore: a large brown one reading "Cotton Dust Kills" and a smaller yellow one which said "And It's Killing Me."

When it was her turn to speak, Linnie Mae Bass cleared her throat and said, "The denim that made blue jeans for you has made brown lung for us. I worked for Burlington Industries for twenty years in the spooling and warping department until I was forced to retire because I couldn't get my breath. I had to come out of the mills seventeen years earlier than I should have. Right now my breathing is only twenty-eight percent normal.

"Mill workers are scared. They are scared of losing their jobs. They are even scared to admit that they are sick because I was myself until I knew.

"We never knew about our rights to compensation for an occupational disease. Definitely the companies have never told us about this disease. You cannot trust the company to do their own education of the people. They cannot be trusted to do their own medical tests. Even Dr. Imbus, Burlington's famous company doctor, cannot be trusted. It has been the Brown Lung Association and not the company that has been educating the people about this disease."

As she talked, Linnie Mae Bass was oblivious to her photogenic attraction to the cotton industry, but Jerry Armour, a photographer for the National Cotton Council of America, dressed in a synthetic blue jean suit lined in red, white and blue, snapped her picture again and again.

Asked why he had been flown from the Cotton Council's Tennessee headquarters to take pictures of the CBLA members, Armour answered, "To show what we're up against." He added, "We're using stills, color slides and sixteen millimeter film. We're going to put together a presentation and show it at the Cotton Growers Association, various board of directors meetings, the National Cotton Council, of course, and to textile manufacturers. We'll probably show it to people like Burlington Industries."

Several months after the CBLA testified at the cotton dust hearings, Dr. Imbus submitted to OSHA a rebuttal of the testimony of disabled Burlington workers on behalf of the American Textile Manufacturers Institute, Inc.

According to Imbus, the testimony of the Erwin chapter of the CBLA "contains distortions, half-truths, and outright falsehoods." Imbus came down hard on Linnie Mae Bass. "It is clear that the individual was advised of the results of every single examination and evaluation that was made regarding her breathing problems."

Few reporters were present in the makeshift courtroom in the small North Carolina town of Lillington when Linnie Mae Bass had her workers' compensation hearing for brown lung.

The hearing was held during the one week in July that the Erwin mill is closed, and the courtroom was filled with mill workers, many of them disabled with breathing problems. And Linnie Mae's fellow CBLA members had traveled from Roanoke Rapids and Greensboro to attend the hearing.

Dr. Imbus, subpoenaed by Bass's lawyer, took the stand. Before the lawyer for Liberty Mutual, Burlington's compensation carrier, moved to strike it from the record, Dr. Imbus verified his signature on a 1971

Elsie Morrison, one of the 10,133 Burlington workers studied for byssinosis in 1971, with her grandchild.

Talbert Faircloth's wife, Dora, died before her husband's final workers' compensation hearing. As his last gesture to his wife, Talbert pinned his Burlington twenty-five year service medal on her before she was lowered into her grave.

document stating that Linnie Mae had irreversible byssinosis.

"Did you tell Mrs. Bass she had byssinosis?" her attorney, Charles Hassell, Jr., asked the doctor.

"No," replied Dr. Imbus.

"Why not?"

"I did not tell *anyone* they had byssinosis. I have assiduously avoided making a diagnosis of byssinosis for anyone. I have relied on outside consultants to make the diagnosis."

"Did you tell Mrs. Bass the results of her test?" her attorney asked.

"I told her that her breathing was abnormally low. To me that is making the results of her test available. I did not give her the detailed results."

Hassell asked again why the company doctor, a recognized byssinosis expert, did not tell Mrs. Bass she had byssinosis when he first learned it in 1971. Imbus, flustered, answered: "Because that word was not known then nor was brown lung."

"What exactly did you tell her?" the lawyer persisted.

"I said your breathing capacity was not what we would expect of a person of your height and weight. She was unable to move the air in and out of her lungs. I told her there was some question of the dust."

Then Imbus testified that Linnie Mae's breathing capacity in 1971 was "fifty-one percent of predicted normal."

The mill workers in the courtroom, many of them coughing and wheezing, did not take their eyes off Dr. Imbus as he ticked off the results of Linnie Mae's breathing tests in successive years:

forty-eight percent in 1973, forty-four percent in 1974, and in 1975, the year she had to leave the mill totally disabled, forty-one percent.

One person not looking at Dr. Imbus was Linnie Mae Bass, who sat with her hand cupping her eyes, shaking her head as she listened to the Burlington doctor confirm under oath what she had contended all along.

I Thought This Was Fishy

Other Erwin mill workers tested and found to have "classic symptoms" of byssinosis in 1971 are making charges against the mill, and they have documentation for what they say.

Talbert Faircloth, one of these workers, received no compensation when he was forced to retire because of his breathing disability. Burlington did not even do the necessary paperwork that would make compensation possible.

Dora Faircloth spoke publicly about her husband's case at a North Carolina Insurance Commission hearing on the insurance industry's requested 28.4 percent rate hike on workers' compensation.

She said, "About a year after Talbert came out of the mill (in 1971), the plant nurse and the personnel man came out to our house and wanted him to sign a bunch of papers. They said that there might be some money in it for him. They came to the house four times, but they never told him what it was for.

"I thought this was fishy, so (in 1973) I wrote to the Industrial Commission to see if Talbert might be eligible for workers' compensation. They said that in order to get compensation, the mill would have had to turn in a Form 19 report on Talbert. The Industrial Commission said that they didn't have any record of a report ever being turned in. Back when Talbert had to leave the mill, we never knew nothing about this Form 19."

Dora Faircloth told the Insurance Commission that her husband learned this past summer that Burlington did not file the Form 19 until September 17, 1976, five years after Faircloth left the mill. The document was signed by the Erwin plant personnel manager directly above the bold print at the bottom of the form reading, LAW REQUIRES REPORT TO BE FILED WITHIN FIVE DAYS AFTER KNOWLEDGE OF ACCIDENT."

Dora Faircloth, irate, asked North Carolina Insurance Commissioner John Ingram, "Did Burlington ever file a report on these (other) 140 people? We think that they didn't.

"They were covering up (in 1971) and they are covering up now. That is how they cover up brown lung and that is how they keep down their insurance rates by breaking the law."

Unlike Dr. Imbus' earlier blanket indictment of the testimony of the CBLA Erwin chapter, this time Burlington was more guarded in the statement it made about Dora Faircloth's charges: "We can neither confirm nor deny the accuracy of these claims."

The CBLA says that until cases like Talbert Faircloth's came to light, the mill companies routinely shunted disabled workers with brown lung to Social Security, where disability only – and not the liability of the employer – is considered in determining that disability payments should be made.

When an ill or injured worker is paid through Social Security disability, the cost is borne by the American people, not the textile mill or the mill companies' workers' compensation carrier.

A few days after Dora Faircloth spoke publicly on her husband's case, she was with her husband in court as Liberty Mutual continued its court battle against Talbert's compensation.

Talbert Faircloth and Hubert West, brothers-in-law, both disabled former Burlington workers.

"I guess they are stalling and stalling until he dies so they won't have to pay him a penny," she said.

Violation of the Safe Load Limit

As the CBLA's membership swells and as more and more disabled mill workers are finding out that their lung problems were caused by their work, the Industrial Commission docket increasingly is jammed with byssinosis cases. The CBLA claims that of the 150 brown lung cases filed in North

Carolina since 1975, less than a dozen have been settled.

Only one case has made it all the way through the North Carolina workers' compensation system and resulted in an award. Otis Edwards, a black J.P. Stevens worker from Roanoke Rapids, was awarded $20,000.

Liberty Mutual originally appealed

Hubert West of Erwin, NC, cried when he read the letter from Liberty Mutual Insurance Company informing him that "due to the fact that you were last injuriously exposed to cotton dust on October 30, 1956, before byssinosis became a part of the North Carolina Workers' Compensation Act, I must inform you that all liability is being denied." Prior to 1963, injuries to "internal organs" were not covered by North Carolina workers' compensation law.

Hubert West has been confined to his home for nineteen years, and has been cared for by his wife, Cora.

the Industrial Commission's decision on Edwards, but later dropped it.

On May 23, 1977, when Otis Edwards had his workers' compensation hearing at the Roanoke Rapids Municipal Court, upstairs from the Police Station, the courtroom was jammed with disabled workers, many of whom would face similar proceedings in their fight to win compensation. And Edwards' fellow CBLA members, including Linnie Mae Bass and a delegation from the Erwin chapter, were there to offer their moral support.

Richard B. Conely, a Deputy Commissioner of the North Carolina Industrial Commission and the hearing officer, looked out at the crowded room and over to the notice posted on the wall reading, "Maximum safe load limit on second floor is seventy-two people. Do not exceed."

"I think we're in violation of the safe load limit," Conely said. "I think we may be exceeding it. I don't know if the floor will cave in."

As pressure builds up, sooner or later it will.

Keeping Occupational Disease Out of the System

The statistics against Otis Edwards winning a compensation award for byssinosis were enormous. Although 100,000 Americans die annually as a result of occupational disease, not more than 500 cases a year are compensated through the workers' compensation system. Peter Barth, Professor of Economics at the University of Connecticut, who with H. Allen Hunt authored a study called "Workers' Compensation and Work Related Diseases," found that "what is disturbing is the pattern to keep the occupational disease cases out of the compensation system. A shocking eighty-eight percent of compensated dust disease cases were contested."

The crisis today in uncompensated and undercompensated occupational diseases is as severe as the situation at the turn of the century when an unconscionable proliferation of the maimed bodies and sundered limbs of American workers caused a national scandal that prompted passage of state workers' compensation laws.

S.B. Black, a past president of Liberty Mutual Insurance Company, recalled the reform spirit of the early twentieth century in an interview he gave in 1950. "I think the philosophy back of workmen's compensation laws was that injury was almost a normal by-product of work, and that perhaps there wasn't very much that could be done about it. Therefore, industry should assume a fair share of the loss that the injured employee sustains."

Liberty Mutual Insurance Company, today the nation's largest workers' compensation carrier and the carrier for seventy percent of the textile industry, grew out of the 1912 Massachusetts law which made workers' compensation insurance mandatory. The first stockholders of the company were the leading Massachusetts industrialists of the day, many of them cotton textile manufacturers.

The industrialists had another motive besides a humane response to the immense toll taken on the life and limb of American workers: they needed to protect their pockets from costly liability suits. The workers' compensation system offered an orderly, no fault method of compensating injured workers through state industrial commissions.

In return, the workers' compensation laws took away the worker's right to sue the employer outside the state-administered system, thereby eliminating the possibility of enormously expensive liability suits. From the beginning, workers' compensation was linked to wages earned. Today in North Carolina, in cases of total disability, disabled workers can collect only sixty-six and two-thirds percent of their weekly wages, not to exceed $80 a week. And textile mill workers are the lowest paid industrial workers in America.

Because the workers' compensation law limits the worker's right to sue an employer, many states protect the worker's right to sue third parties. Omry Glenn of Columbia, South Caro-



lina, a member of the CBLA and a diagnosed byssinosis victim, is the first brown lung victim to have filed a third party suit. In his million dollar suit, Glenn has sued the manufacturer of the mill machinery and ventilation system for "negligence, recklessness and willfulness" for designing equipment in such a way that it would "create dust and/or chemicals," causing Glenn to become "permanently disabled."

Glenn's attorney, Ronald Motley, said, "If the insurance carrier undertook to advise the company on safety, we're going to sue them, too."

Dr. Arthur Larson – professor of law at Duke University, a leading authority on workers' compensation and an Undersecretary of Labor in the Eisenhower administration – has written, "By failing to keep compensation benefits up to the standards and needs of the times, great pressure has built up for supplementing compensation benefits in other ways." One of these ways is third party suits.

Discussing the nation-wide trend towards suing insurance carriers, Dr. Larson noted (in his *Treatise* on workers' compensation) that "what really set off alarm bells" was the 1961 case in which the Illinois Supreme Court "upheld a judgement of $1,569,400 against a carrier based on a negligent performance of a gratuitous safety inspection. Perhaps the sheer size of the judgement added to the shock." Larson also pointed out that the case stands as "a clear decision without dissent that a compensation carrier can be made liable as a third party in tort for negligence in safety inspection. After this case, suits against insurance carriers appeared in jurisdiction after jurisdiction."

Of course, the insurance industry is not taking this lying down. In a countermove, in states like New Hampshire, the legislature has amended portions of the workers' compensation law so that insurance companies are exempt from liability as third parties. As Dr. Larson noted wryly in an interview, "When it comes to legislature, insurance companies are no slouches."

In North Carolina, the insurance industry lobby, the largest and most effective in the state, spent $40,865 last spring on legislation to reduce Insurance Commissioner John Ingram's power.

Not Supposed to Talk

Liberty Mutual's vulnerability to third party suits stems from its participation in the 1971 Burlington byssinosis survey. The insurance company's role came to light in testimony given at the cotton dust hearings by Dr. Moon W. Suh, senior operations research analyst for Burlington Industries. Dr. Suh testified that Liberty Mutual conducted the sampling of cotton dust levels in nineteen Burlington mills that "constituted the data base" for the study.

Russell Van Houten, Liberty Mutual's director of field services, confirmed that the company had conducted extensive cotton dust testing "at least as far back as 1968."

Liberty Mutual offered its services as safety inspector in testing cotton dust levels to other companies as well. About five years ago, Liberty Mutual did the "raw cotton dust testing" in Cone's twenty-two plants producing cotton fabric. Dr. Theodore H. Hatfield, J. P. Stevens' first medical director, appointed in 1976, said that "Liberty Mutual was instrumental in encouraging the company to bring me here." Hatfield said that Stevens had "twenty-seven or twenty-eight plants that have significant exposure to cotton dust."

And Samuel Griggs, who heads Stevens' dust sampling program out of its Environmental Services Laboratory in Piedmont, South Carolina, said: "Before we were not encouraged and not required to do tests. We used to depend almost entirely on Liberty Mutual. We'd call them up and ask, 'How do we get out of trouble?' I mean, if we thought we had a problem.

"As far as cotton dust goes," Griggs said, "we'd tell Liberty Mutual, 'we'd like for you to come in,' and they'd come in and survey the plant. They'd do an overall survey."

Griggs stopped talking suddenly, then said, "This doesn't connect with labor, does it? We're not supposed to talk about labor."

If occupational health and labor relations are not linked in the mind of Stevens' environmental safety person-

nel, top level Stevens management does make the connection.

Even as Samuel Griggs talked last spring, Joseph Jelks, Stevens Vice President in charge of Industrial Relations, was winging to Boston for a high-level meeting with Liberty Mutual. Jelks is on Liberty Mutual's Advisory Board for South Carolina. Half the members of Liberty Mutual's North Carolina and South Carolina Advisory boards are top textile executives.

Liberty Mutual president Melvin B. Bradshaw does not seem aware that his company is vulnerable to third party suits resulting from possible negligence in serving as a safety inspector in the mills.

Bradshaw said, "Our vulnerability is covered by law. It is totally unthinkable that the carrier that is asked to uncover hazards is then sued for it."

Bradshaw appeared impervious to the suggestion that his company has a direct obligation to endangered workers. In a telephone interview in the spring of 1977, when asked if Liberty Mutual felt any obligation to inform endangered Burlington workers that it had found dusty conditions in Burlington mills, Bradshaw responded: "I don't believe it is our prerogative to give employees this information. We do this work strictly as a consultant to the company. I'm sure we told Burlington."

Linnie Mae Bass, CBLA member and disabled Burlington worker, said, "We have been paying too long with our lives. It is time for the mill companies to start paying."

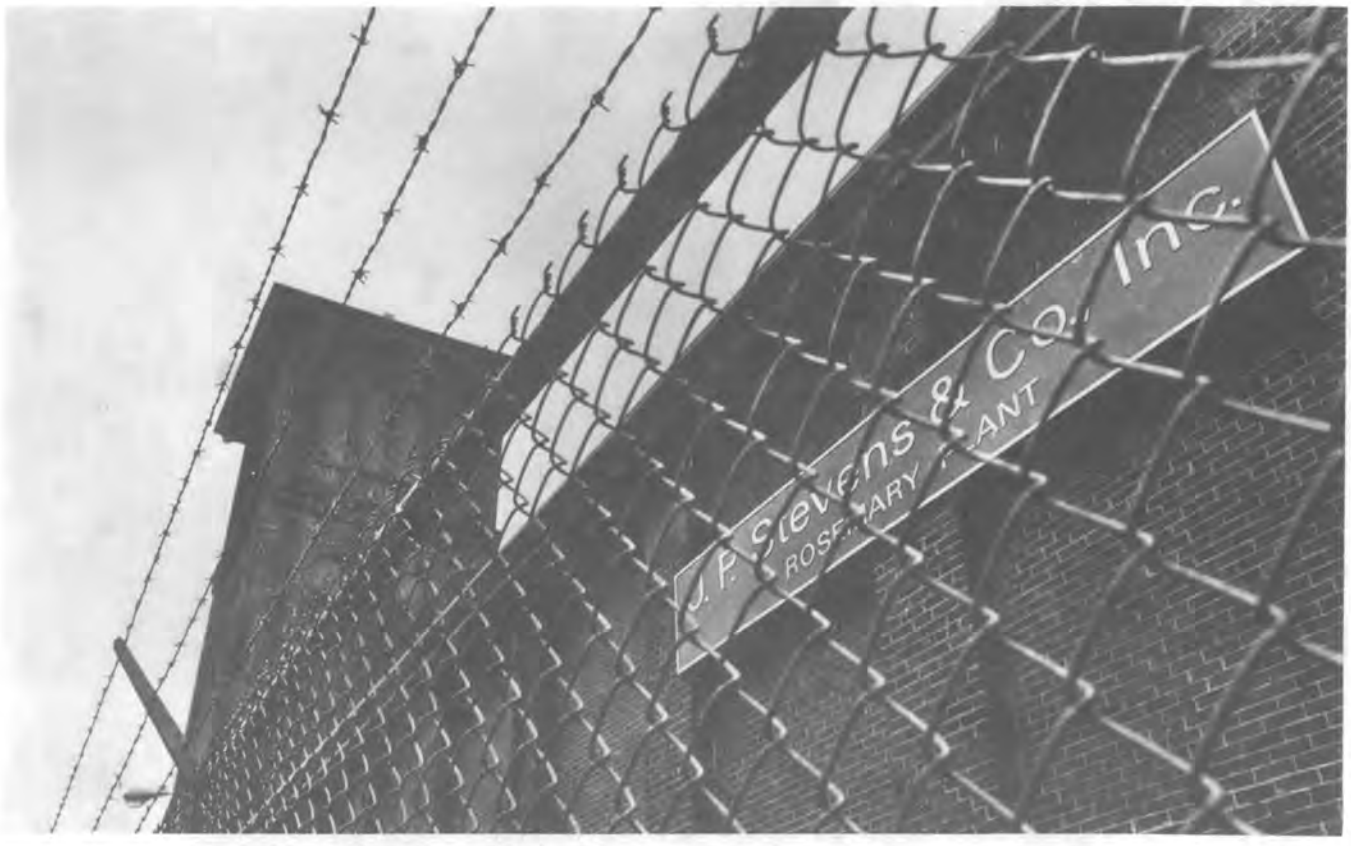
He added, "If they are working in the mills, they must know it's dangerous. To what extent it's dangerous, I don't know."

I've Got a Hurting All Across My Body

Some observers feel that the present workers' compensation system can not deal with byssinosis claims in the Carolinas. One of these is Ernest Hollings, US Senator from South Carolina, where the state motto is "While I Breathe, I Hope." Hollings has introduced a brown lung measure in the Senate. US Representative Phillip Burton introduced a byssinosis bill in the House in February, 1977.

A South Carolina delegation of the CBLA called on Senators Strom Thurmond and Ernest Hollings and the South Carolina Congressional delegation in April, 1977, after testifying at the cotton dust hearings.

Thurmond told the brown lung victims, "You all speak out now! We *want* to hear from you people!" The CBLA needs no prompting. Time is short for these people who are devoting their last days to cleaning up the mills and winning compensation



Earl Dotter is a free lance photo-journalist specializing in labor subjects with emphasis on workplace health and safety. Special thanks to the Highlander Center for helping to make these photographs possible.

for brown lung.

The South Carolina delegation of the CBLA told their Senators and Congressmen that J. H. ("Hub") Spires, the first president of the Association, had been buried the day before, his lungs so riddled with disease that his doctors could not risk a necessary operation.

And Lonnie Moore, then president of the Spartanburg Chapter, got right to the point: "We want the mills to clean up or ship out. One of the two. If they had wanted to put in cleaner equipment, they would have done it by now. I've been in there for forty-six years, and they still haven't cleaned it up.

"Now I've got a hurting all across my body. I just hurt all over. My last day in there, at Mount Vernon Mills, I got so sick I couldn't stand up. The company wouldn't even let me call an ambulance.

"The overseer wouldn't even call my wife for me. When I got on the phone to ask her to carry me to the hospital, my wife thought I was a child, my voice was so faint.

"When I got to the hospital, the doctor told me, 'Your lung is full of fiber. Get out of that mill or make your funeral arrangements.'"

Looking at each of the politicians, Lonnie said, "Now *you* need our help just like we need your help. And we're telling you, we need some help *now*."

Before the Senators and Congressmen could respond, the room was filled with shouts of "Amen!" "Amen, brother!" "Tell it like it is, Lonnie!"

Senator Hollings rose to his feet. "In old-time politics, you could always sneak into the mills and get the votes. I'd always come out coughing. And I had to carry a special campaign suit that wouldn't pick up lint. I've always wondered how you all did it.

"Maybe we could bring this to a head. I'm going to introduce a bill. Maybe we should look at that black lung legislation and make a special bill like that for you. There may be some problems, but one way or another, I'm going to introduce a bill to deal with compensation benefits and this OSHA question."

"I think it's a good thing to save a person's health. That's what the CBLA is fighting for. That's what I'm fighting for," said Linwood Baugham, a disabled worker and CBLA member.

Interviewed after the meeting with the CBLA delegation, Senator Hollings said he had promised to introduce legislation because he was moved by what the CBLA delegation had said. Then he added, "But I want to emphasize that I can't say I didn't realize they had breathing problems before. I can't say I didn't know about conditions in the mills.

"But I'm tired of the indecisiveness. Something has to done for these people. If you work for fifty-three years in a cotton mill and end up on welfare, something's wrong."

I asked Hollings, the former Governor of South Carolina, about the current drive for unionization of textile mills in the South. "There's no labor movement afoot in my state. But it seems to me that if these people don't get remedial action on this [brown lung issue], that would be reason to organize and have a union." □

Mimi Conway has written about the Southern textile industry and brown lung for three years. The research for her article was made possible by a grant from the Fund for Investigative Journalism.

The Great Hookworm Crusade

by Allen Tullos

Throughout the nineteenth century, the Southern clay eater, that convenient fool of travelers' accounts, journalists' sensations and physicians' observations, resisted a bellyful of hardship which might have convinced a weaker creature to seek extinction. Confined for generations to the sandiest and most barren portions of the South's soil, where they were said to feed upon cornmeal and hog meat, the clay eaters became legendary for ignorance, filth, laziness and immorality. Despised by blacks for their shiftlessness and lamented by whites as degenerate descendants of almost pure Anglo-Saxon stock, these "poor whites" nonetheless managed to fatten the pages and nourish the careers of those writers remembered today as local colorists. In *Georgia Scenes*, for example, the antebellum humorist Augustus Baldwin Longstreet offers the character "Ransy Sniffle."

> Now there happened to reside in the county, just alluded to, a little fellow, by the name of Ransy Sniffle: a sprout of Richmond, who, in his earlier days, had fed copiously upon red clay and blackberries. This diet had given to Ransy a complexion that a corpse would have disdained to own, and an abdominal rotundity that was quite unprepossessing. Long spells of the fever and ague, too, in Ransy's youth, had conspired with clay and blackberries, to throw him quite out of the order of nature. His shoulders were fleshless and elevated; his arms, hands, fingers and feet, were lengthened out of all proportion to the rest of his frame. His joints were large, and his limbs small; as for flesh, he could not with propriety be said to have any.[1]

By the start of the twentieth century, long after the Georgia clay had swallowed Longstreet, Ransy Sniffle and his kin remained. They had survived, perhaps had even been oblivious to the War, Reconstruction, Redemption and the collapse of agrarian revolt. These were mere trials for what lay ahead. For they had never met so meddlesome or so persistent an invader as "The Uplift." Nor did the schoolhouse of Progress allow truants.

One day in 1908, Ransy Sniffle propped himself against the stationhouse wall of a small railroad town somewhere in the South. In the smoking car of a passing train, three members of President Theodore Roosevelt's Commission on Country Life sat speculating upon what one of them called "this land of forgotten men and forgotten women." Henry Wallace, an Iowan unacquainted with crackers and sandhillers, noticed Ransy first. "What on earth is that?"

"That," said Walter Page, journalist and social reformer, "is a so-called 'poor white.'"

"If he represents Southern farm labor," Wallace replied, "the South is in poor luck."

Then, Dr. C. W. Stiles startled both Page and Wallace. "That man is a dirt-eater. His condition is due to hookworm infection; he can be cured at a cost of about fifty cents for drugs, and in a few weeks' time he can be turned into a useful man.

"The hookworm," Dr. Stiles explained, "is a parasite picked up in larval form by barefooted Southerners, particularly children. Boring through the skin en route to the bloodstream, hookworm larvae produce symptoms known as 'ground itch' or 'dew poison.' Carried by the blood to the lungs, they are coughed into the throat, swallowed, then move through the stom-

---

Allen Tullos, a native Alabamian, is currently in the American Studies graduate program at Yale University. All photos courtesy of Rockefeller Foundation Archives.

Live hookworm exhibit at the Kentucky State Fair in 1913.

ach toward the small intestines. There the worms attach their mouths to the intestinal membrane, feed upon their hosts' blood and grow to full size – about one third of an inch long. Mature hookworms lay eggs which pass into human feces; they hatch and thrive in portions of the American South as well as in a number of subtropical countries where there is a combination of warm temperatures, frequent rainfall and sandy soil. A microscopic examination can detect the presence of hookworm eggs in human specimens and a dose or two of thymol and epsom salts provides a quick cure.

"Bad habits of human waste disposal ('soil pollution')," Stiles continued, "have led to the infection of as many as two million Southerners, most of them poor whites. Severe sickness (by five hundred or more worms) produces acute anemia and occasional death. Less severe infection weakens the victims and leaves them susceptible to other illnesses such as pneumonia and tuberculosis. Most commonly, the disease goes unrecognized and its victims feel continually weak."[2]

Within weeks after this train ride revelation, Walter Page arranged for Stiles to tell his hookworm story to Frederick Gates, a former Baptist minister who was now the chief adviser in the philanthropies of John D. Rockefeller. Within months, the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease was formed with one million dollars of Rockefeller money promised for five years' work.[3] So began, in 1909, a campaign to transform Ransy Sniffle into a full-bodied participant in an industrializing New South.

The hookworm campaign was sustained by the myths of its time and was conducted by a complex company of interdependent characters. In part, it is a tale of hookworm determinism as a theory of history seriously proposed by a zoological specialist and eagerly accepted by regional boosters. It is also a story about the conception of human potential and the aims of philanthropy as understood by the royal family of American capitalism. And, despite its entanglements with the bugbears of racism and "the civilizing process," it is a story of the emergence of widespread public health work in the Southern states.

"Germ of Laziness Found"

The son of a New York Methodist minister, Charles Stiles spent his life as a sanitation missionary. In 1886, at age eighteen, he began the study of medical zoology, seeking instruction at universities in Berlin, Leipzig, Trieste and Paris. Investigating internal parasites, young Stiles made the acquaintance of *Ancylostoma duodenale*, the Old World hookworm known in Italy and Switzerland since the mid-nineteenth century as a cause of severe anemia among tunnel workers, brickmakers and miners.[4]

Stiles determined from temperature, climatic and soil conditions that the New World probably had its share of hookworm disease, yet when he returned to the United States in 1891 to work as a zoologist for the Bureau of Animal Industry, he found no sample of human hookworm in the Bureau's collection. It was not until 1901, when Stiles examined samples of hookworms sent from Puerto Rico and from Texas, that he discovered the new species which he named *Necator americanus*, the "American murderer." A few years later, when Dr. Arthur Looss found *N. americanus* among African natives, it became evident that this species had actually come to America as a baggage of the slave trade.[5]

In 1902, Stiles maneuvered himself from the Department of Agriculture into the US Public Health Service and undertook a Southern survey trip to explore the distribution of hookworm. Sampling his way southward from Washington with as yet a vague notion of the parasite's favorite soil, Stiles also encountered the resistance of miners and brickyard workers to a Yankee doctor who wanted "specimens." By the time he reached the sandy lands of South Carolina, Stiles had uncovered only a few cases. Finally, in Lancaster County, he "found a family of 11 members, one of whom was an alleged 'dirt-eater.' The instant I saw these 11 persons I recalled Little's (1845) description of the dirt-eaters of Florida....A specimen from one of the children gave the positive diagnosis of infection."

Continuing through Georgia and into Florida, Dr. Stiles found dozens of infected farm families and factory workers. He also discovered that the disease showed more severe symptoms among whites than blacks. During this three month excursion, Stiles discussed his findings with a Southern medical society and conducted several small clinics, demonstrating the hookworm cure to local physicians.[6]

"So began, in 1909, a campaign to transform Ransy Sniffle into a full-bodied participant in an industrializing New South."

Inspired, one Atlanta doctor, H. F. Harris, made his own field trip through Georgia and into Florida. Harris was

> . . . much astonished to find that this disease affected a large percentage of the population in many districts, the unfortunate sufferers being generally regarded as dirt-eaters . . . . I discovered the fact that almost all instances of profound anemia were due to the uncinaria [hookworm], and not, as has been heretofore generally assumed, to the malarial parasite.[7]

Other Southern doctors were soon making similar discoveries.

In December, 1902, Stiles summarized his Southern trip before an annual meeting of the Pan-American Sanitary Conference in Washington, DC. The New York *Sun* gave his comments front page treatment under the headline "GERM OF LAZINESS FOUND? DISEASE OF THE 'CRACKER' AND OF SOME NATIONS IDENTIFIED." According to the *Sun*, Stiles declared that the presence of hookworm in the South had caused "the pitiable condition of the poor whites. Its presence in succeeding generations had resulted in their inferior physical development and mental powers and is the cause of the proverbial laziness of the 'cracker.'" Stiles added that, "Attention paid to this matter by planters and farmers in the Southern States would result in not only improved conditions generally, but a great increase of the percentage of work which they would secure from their employees."

Continuing, Stiles made another assertion, one which would bring him criticism from members of the child labor movement. Because stunted

A morning clinic at a State and County Free Dispensary for Hookworm Disease, held in 1911 in Onslow, North Carolina. C.W. Stiles is at center, to left of post.

growth was one effect of hookworm disease, and because he had discovered several hookworm-infected mill workers as old as twenty-eight who looked only half their age, Stiles concluded that child labor reformers were generally deceived regarding the ages of factory hands.[8] In fact, a Census Bureau study of 1900 had shown that three out of ten workers in Southern mills were children under sixteen and 57.5 percent of these children were between ten and thirteen years of age. And although their wages were much lower, the children's eleven and twelve hour days were no shorter than those worked by their parents.[9]

Across America, newspapers and magazines picked up the *Sun*'s story of Stiles' discoveries and while humorists took aim once again on Ransy Sniffle, that tired caricature with many names, other writers sighed, "How much of the South's past does Stiles' theory explain! How much for the South's future does it promise."

Years later, reflecting on the *Sun* article, Dr. Stiles wrote that it had been "an exceedingly valuable piece of work in disseminating knowledge concerning hookworm disease." In praise of the newspaper's use of the "germ of laziness" expression, he noted, "It would have taken scientific authors years of hard work to direct as much attention to this subject."[10]

During the years after 1902 until the meeting with Page and Wallace in 1908, Dr. Stiles worked single-mindedly for his cause. Filled with the zeal of turn-of-the-century reformism, he combined valuable insights of preventive technique with the changing etiquette of modern life:

> My hobby may be summarized in the two words: "Clean Up." In our filthy American habits of daily life, I see the cause of more preventable sickness and preventable death than I do in any other one factor. . . . Think of it my friends, that despite the agitation on the subject of tuberculosis, we Americans have not yet shown the moral courage to stop that filthy and pre-eminently American habit of promiscuous spitting, and think of it, that 55% of the American farm homes of which I have record have no privy, but are permitting a continuation of the Andersonville stockade soil pollution.[11]

At medical schools and at state medical conventions Stiles presented papers, offered demonstrations and exhibited hookworm patients. In 1903 he wrote a bulletin for the Public Health Service's Hygienic Laboratory which included a discussion of sanitary privies. At first denied publication on the grounds that such a topic was too disgusting for a scientific paper, Stiles eventually saw his pamphlet printed; 350,000 copies of another Stiles bulletin on privies and the safe disposal of "night soil" were distributed free by the US Department of Agriculture. These pamphlets continued to present his "conservative view" of the economic significance of hookworm disease "as one of the most important factors in the inferior mental, physical, and financial conditions of the poorer classes of the white population of the rural sand and piney wood districts. Remove the disease and they can develop ambition."

Stiles' lobbying in behalf of Southern sanitation gained little for him in Washington except the nickname of "Privy Councillor." As yet unwilling to underwrite an intensive government campaign, administrative officers in the Treasury Department apparently squelched the request of South Carolina Senator Ben "Pitchfork" Tillman for a $25,000 hookworm appropriation. Determined, Stiles continued in solitary fashion.[12]

The Rockefeller Sanitary Commission

At the beginning of the twentieth century, Southerners were living amidst overwhelming poverty. The post-War emergence of the crop lien system had developed into sharecropping, a new sort of slavery with both white and black victims. The rise of textile mills – that great hope for which New South boosters of the 1880s and '90s offered investors low taxes, free land and unorganized labor – was creating a growing population of wage slaves. Native ores, minerals and timber were being hauled away as fast as Northern owners (Mellons, Morgans, DuPonts and Rockefellers) could lay tracks to their mines, mills, forests and wellheads. "The advance of industry into this region," concluded geographer Rupert Vance in 1932, "then partakes of the nature, let us say it in all kindliness, of exploiting the natural resources and labor supply of a colonial economy."[13]

From the point of view of Yankee philanthropists who began to tour the South annually in 1901 aboard special trains organized by New York merchant-churchman Robert Ogden, widespread poverty and backwardness were drags upon Progress. Soon these Northern men of money and their Southern agents began a series of campaigns, each aimed at a specific deficiency, which combined humanitarianism with the aggressive attitudes, efficient methods and narrow-minded goals of modern business.

The first of these large-scale organizations for Southern do-good was the General Education Board. Between 1902 and 1909, the John D. Rocke-

fellers – Senior and Junior – placed $53 million into the GEB, underwriting a survey of rural education conditions, promoting state school building campaigns and paying the salaries of several professors of secondary education at state universities. Turning to agriculture, the GEB supplied money for the work of Seaman A. Knapp, the developer of demonstration farming. With its director, Baptist minister Wallace Buttrick, as a plump example, the General Education Board learned to spawn effective South-wide campaigns by drawing its leaders from the region's college presidents, ministers and editors.[14]

These "estimable gentlemen with high collars and fine principles," C. Vann Woodward has written, "were very much in earnest, but the changes they envisioned included no basic alteration of social, racial, and economic arrangements."[15]

One of these philanthropic professionals was expatriate Southerner Walter Page who, as a member of various boards, governmental commissions and private coteries, energetically pursued the redemption of the South from his bases in Boston and New York. Page's 1897 address, "The Forgotten Man," sounded a call of rescue for poor whites and blacks, and signaled a shift in the emphasis of the Uplift from mill construction to education. By 1908 Page was ripe for the discovery of that most forgotten of men, Ransy Sniffle, and for Dr. Stiles' hookworm evangelism. It was Page who put Stiles in touch with GEB secretary Buttrick. An all-night conversation with Dr. Stiles convinced Buttrick to arrange a further meeting, this time with Frederick Gates – the chief steward of Rockefeller philanthropy.[16]

After long discussion over the details of staff and operations, the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease was organized on October 26, 1909, with a pledge of one million dollars for five years' work. Drawn primarily from the trustees of other Rockefeller philanthropies (ranging from the GEB to the Rockefeller Institute for Medical Research), the Sanitary Commission board of directors consisted of twelve men: Page, Stiles, Gates, Rockefeller Junior, Starr Murphy, P. P. Claxton, David Houston, J. Y. Joyner, H. B. Frissell, E. A. Alderman, William Welch and Simon Flexner.[17]

Wickliffe Rose, Tennessee native, philosopher and secretary of the Peabody Fund, was chosen as administrative secretary at a salary of $7,500 plus expenses. Sensitive of the Southern temperament regarding Yankee invasions of any sort, Rose's first act was to rent an office for the Sanitary Commission, not in New York but in Washington. Already a chorus of outraged Dixie newspapers were protesting. "Where was this hookworm or lazy disease," asked the Macon, Georgia, *Telegraph*, "when it took five Yankee soldiers to whip one Southerner?" A North Carolinian suggested the campaign was just another Rockefeller scheme to make more money by going into the shoe business.[19]

"From the point of view of Yankee philanthropists who began to tour the South aboard special trains, wide-spread poverty and backwardness were drags upon Progress. Soon these men of money began a series of campaigns combining humanitarianism with the efficient methods and narrow-minded goals of modern business."

"We have had to overcome"

In their seven years of Southern experience prior to the hookworm crusade, the Rockefeller advisors had learned that success depended upon acquiring state and local government support for their projects. As Wallace Buttrick explained it in a 1925 speech to the New England Society, the philanthropists wanted to be thought of as "partners not patrons," functioning in the background while the day-to-day responsibility was in the hands of cooperative state authorities.[20]

To conquer the hookworms, the Sanitary Commission set three tasks: determining the geographic distribution and estimating the degree of infection; curing the infected; and stopping "soil pollution." Before entering any state, the Commission would wait for an invitation from that state's board of health. A physician would be hired (as recommended by the state board and approved by the Commission) to act as state director. Then a field force of sanitary inspectors, a handful for each state, would be nominated by the state director and approved by the state board of health and the Commission. By November 1, 1910, state directors had been appointed and work begun in Virginia, North Carolina, Georgia, South Carolina, Tennessee, Arkansas, Mississippi, Alabama and Louisiana. Kentucky and Texas were added in 1912. Florida started its own campaign before the Commission was organized, financing it through public health taxation.[21]

Wickliffe Rose proved a tactful and industrious administrator, corresponding continuously with public health officials, organizing meetings of the state campaign directors, traveling through the South to confer with boards of health. He continued to be particularly cautious in any matters which might arouse regional prejudice. Responding to an invitation by Walter Page to speak to the Round Table, a New York club whose members came from the intellectual community around Columbia University, Rose wrote in October of 1910:

> I too meant to speak to you about the talk before the Round Table. I wanted to ask you first if you wanted me to tell about our work in the Southern States, and second, whether this could be done without its getting into the papers. Now that I see the program is to be printed and sent out I wish you would have called this off in the proper way. You know how sensitive our people are about having any man go to New York and talk about things that are being done in the Southern states. You know how much opposition was created by the press of the South by the publicity given to this work in the beginning. We have had to overcome. Everything is now going our way; all opposition is disappearing. I would not for the world do anything to interfere with the complete success of this work. For the present it is extremely important that the talking and writing be done in the South from the State Boards of Health.

Rose suggested that the topic of his talk be "Conservation of Country Life" for "this would be delightfully indefinite, at least, and would give a man oppor-

"We had not known until then that we were backwards."

For years we had a place at school called "down the hill." It was a grove of trees a few hundred yards behind the school house where we went at recess time for toilet purposes. There were no plumbing facilities in the building and not even an outhouse nearby. So we used the woods, each little clique having their own favorite place which the members would use and guard with fervor and dedication against any who dared threaten their territorial rights. But a W.P.A. project had recently built a "facility" for our use and we were told never to relieve ourselves outside that structure again because, it was carefully explained, such a practice led to the spread of the dread hookworms.

We saw this as oppressive in itself, but the day a technician from the State Health Department visited the school with a program to detect who among us already had hookworms we were morally outraged.

First the man explained that he was operating with a grant from Washington. This, we supposed, to indicate the magnitude of what he was about to say. He said the purpose of the grant was to rid our community of hookworms, adding that the South was backward, not so much because of the Civil War, but because of malaria and hookworms. (We had not known until then that we were backward and therefore had not pondered the possible reasons for our backwardness.) He passed out a mimeographed, one-sheet set of instructions, rolled around a small tin can looking then like a snuff can and looking now like a container for filmstrips. Total silence was required for five minutes while we read what it was we were expected to do.

"Are there any questions?"

There were no immediate questions because no one understood enough of what he had read to evoke a question.

Now the principal spoke. "Now if any of you have any questions you had better ask them now because every last one of these specimen cans must be returned tomorrow."

This did elicit a question and one of the high school boys asked it for all of us.

"What is a specimen?"

"A specimen is . . . " The principal glared at the visitor who appeared relieved that the question was not directed at him. Mr. Stuart continued.

"A specimen is . . . a specimen is a small amount of something."

Now we knew how much but we didn't yet know how much of what. The instruction sheet had said to place a specimen of feces in the container, write our full name and the names of both our parents on the label, and return it to school the following day. But "feces" was no more a word of our vocabulary than "specimen."

Gradually it began to dawn on us in the form of a very vague notion that the entire operation had to do with what we called "taking a crap." But it had not yet come into clear focus for any of us. And did not during the whispering and mumbling that was going on throughout the hall, not until one of the smaller boys, thinking that he was speaking softly enough so that he would not be heard by anyone except himself, said, "I know. He's telling us to go home and shit in a snuff can."

What he said was heard by those immediately surrounding him. They in turn shared it with others and in not more than a minute howls and uncontrollable laughter had spread over the auditorium like the fires that came to the Moore Pasture in early spring.

The embarrassed representative of the Health Department stood glowering at the principal, arms folded tightly across his chest. The rage of the principal was so obvious to us that the noise subsided as quickly as it had begun. Now the hall was a sea of compelled silence, all the boys sitting with teeth clenched, lips drawn tightly together to hold the thundering mirth churning and tearing at our insides, bellies almost bursting from our efforts to control muscles which would not be controlled. And when the principal, seeing that the tortuous restraint would not hold for long, said, "That's all," every voice exploded and there was pandemonium. School was out.

Now we were far back in the Moore Pasture woods, laughed out, not finding any of it funny anymore.

All of us resented the idea that the government had the right to know what our "feces" looked like. And we found no humor in this demeaning act of having to bring ourselves to such close contact with our body waste. Still we knew that it must be done.

But Joe, lagging behind the rest of us, reading again the instruction sheet, found a means of protest.

"It says, 'place *a* specimen of feces' in the container. It doesn't say, 'Place a specimen of *your* feces' in the container." The creative dissenter was right. Of course! One boy could provide the specimen for us all.

But which one? Joe said since it was his idea he should be excepted and asked for a volunteer, looking straight at me in a manner that told me I should not offer. When no one volunteered he suggested that we say, "eeny, meeny, miney, moe. Catch a nigger by the toe. If he hollers, make him pay, fifty dollars every day." Joe had earlier shared with me the method he had of making that come out wherever he wanted it to. There were many combinations, but by first counting the number of persons and starting the rhyme with the person on his immediate left, he knew in advance which one would be chosen.

As is so often the case with social protest and community organizing there was a problem we had not reckoned with. When the laboratory report was returned we learned that our common donor *had* hookworms, meaning we *all* had hookworms and all of us were required to undergo the treatment or confess to our misdeed. We chose to swallow the pills, big pills, almost the size of bird eggs.

Joe, who was later to become a scientist himself, raised a question about the scientific method which had not occurred to me. He wondered why the researcher did not find it strange that while *all* the Campbell boys had hookworms, not *one* Campbell girl was found to be similarly infested.

— Will D. Campbell

Brother to a Dragonfly

(Reprinted with the permission of The Seabury Press. "Preacher Will" has been nominated for a National Book Award for his biographical reminiscence of his brother, Joe. His book, Brother to a Dragonfly, *is reviewed in the Book Review section of this issue.)*

tunity to say practically anything he pleases."[22]

Expert in matters of propaganda, Rose regularly gave advice to his state directors. Enclosing a copy of the Commission's first annual report, he suggested to Virginia's Dr. A. W. Freeman how to use it for best publicity purposes.

> It seems to me important that any publicity given it should be given through the medium of one or two of the leading papers in each of the states. If the paper which you select should notice it first, the chances are that any notice given it would be favorable.[23]

Arkansas, the only Southern state having no public health budget in 1910, was completely dependent on Rockefeller money. Nonetheless, Rose wrote to the Commission's Arkansas office,

> I beg to advise you that your office be styled, office of the Arkansas State Board of Health. I should think it might be well to omit all reference to the Rockefeller Commission. It is our desire that everything be done so as to attract attention toward the State Board of Health and to create interest in its development.[24]

Despite the efforts of Rose, Arkansas proved a troublesome state. When its legislature passed a public health bill in 1911, the bill was stolen before it reached the governor. A copy of the bill was prepared and signed, only to be declared invalid by the state attorney general. Frustrated, Arkansas hookworm campaign director Morgan Smith wrote to Rose:

> You cannot have the slightest conception of the feeling engendered by this Bill, and so acrimonious have been the discussions and so intensely strained the relations of those who stand for right and those who represented the pernicious interests, that personal conflicts were hard to avoid....The National League for Medical Freedom fathered the opposition and no doubt furnished the money. That the bill was stolen and somebody received money for doing the work is so strongly fixed in my mind.[25]

While Rose guided the administrative affairs, Dr. Stiles was traveling throughout the South, presenting technical as well as popular addresses to a variety of audiences and occasionally assisting in clinics. He was the leading presence at the first Southern conference on hookworm, held in Atlanta on January 18 and 19, 1910. This event brought together doctors from throughout the region and its proceedings were given extensive coverage in four issues of the *Journal of the American Medical Association*.[26] At the request of Rose, Stiles wrote a Public Health Service bulletin on hookworm symptoms and treatment for distribution to physicians.[27] He met with a textile mill owner in an effort to get more privies built in mill villages. He conducted a personal sanitation survey (1910) of nearly five thousand farm homes in six Southern states which revealed that thirty-five percent of the white homes and seventy-seven percent of the homes occupied by blacks had no privies.[28]

In an address given at Hampton Institute in 1909, Stiles explored the implications of the less severe effects of hookworm disease on blacks as compared with whites, an observation he had first made in 1902. He speculated that "the negro race had this disease for so many generations in Africa that it has become somewhat accustomed to it." With their "relative immunity" from the most debilitating effects of hookworm disease and with their higher incidence of soil pollution due to their greater lack of privies, blacks, said Stiles, became ideal spreaders of the disease. "The white man owes it to his own race that he lend a helping hand to improve the sanitary surroundings of the negro."[29]

Stiles' observations on black sanitary improvement came at a time of deteriorating race relations throughout the US.[30] Many newspapers and periodicals injected their own interpretations and the code words of racism into Dr. Stiles' remarks. In an article for *McClure's Magazine* entitled "The Vampire of the South," Marion Hamilton Carter wrote:

> Negro crimes of violence number dozens where his sanitary sins number tens of thousands. For one crime a mob will gather in an hour to lynch him: he may spread the hookworm and typhoid from end to end of a state without rebuke.[31]

Perhaps the most extreme connection of black "sanitary sins" with the plight of poor whites and the mechanistic vision of progress appeared in Dr. Charles Nesbitt's "The Health Menace of Alien Races," an article published in *The World's Work*, a popular magazine founded by Walter Page.

> In 1902, Dr. Stiles discovered that the hookworms, so common in Africa,

Two thirteen-year-old boys. The smaller boy is infected with hookworm, showing the dwarfing due to the disease.

- Severe hookworm produces anemia and, occasionally, death.
- Less severe infection leaves the victim susceptible to other diseases.
- Most commonly, hookworm goes unrecognized, although its victims feel continually weak.

Varieties of hookworm dispensaries and examination programs occurred throughout the area served by the Sanitary Commission, from the field exam shown above in Waller County, Texas, to the group holding forth in a hotel lobby in Rochester, Kentucky. The latter town had the distinction of conducting the largest number of examinations in proportion to its population, and finding the lowest percentage of infections, of any of the Commission-sponsored projects.

which were carried in the American Negroes' intestines with relatively slight discomfort, were almost entirely responsible for the terrible plight of the Southern white. It is impossible to estimate the damage that has been done to the white people of the South by the diseases brought by this alien race. Physical inefficiency and mental inertia are its results. Every enterprise that locates in the South today, if it uses the available white labor of the South, must reckon on not more than 40 to 60 percent of normal efficiency. As this phase of the race problem continues to be studied, it is inevitable that further investigation will produce still stronger evidence that the races cannot live together without a damage great to both; so great, that even now the ultimate extinction of the Negro in the United States is looked upon by many as assured. We also know that as his extinction progresses it is carrying tremendous damage to the white race.[32]

The Clay Eaters

If Ransy Sniffle's lot in life could be conveniently traced to black health criminals, many of his favorite eating habits (which offended genteel propriety) were certain to be the result of hookworm infection. Frances Bjorkman was not the only journalist who, after traveling in the land of crackers, sandhillers, barrenites, pinelanders and shadbellies, concluded that "dirt-eating, alcoholism, snuff-dipping, incessant tobacco chewing – together with many other common perversions of appetite, such as resin-chewing, coffee chewing, and a morbid craving for pickles and lemons – had their origin in the derangement of the digestive tract caused by hookworms."[33]

Nor could any Southern schoolchild have failed to know the hookworm catechism as written by Dr. Stiles and distributed by the tens of thousands.

Question 40. What is a dirt-eater?
A dirt-eater is a person who has an unnatural appetite, and on this account eats clay, sand, plaster, soot, wood, cloth, or other things not intended for food.

Question 41. Is dirt-eating the cause of hookworm disease?
It is the result of the disease, not the cause.

Question 42. Can dirt-eating be cured?
Yes, very easily; by curing hookworm disease.[34]

Yet, despite the crusaders' certainty, today the dirt-eating question remains unresolved. A review of recent scientific studies of *pica*, the desire to ingest and

the ingestion of substances usually considered inedible, leads to several limited conclusions. Iron deficiency anemia of the sort caused by hookworm disease is common where pica is severe, but iron deficiency hasn't been conclusively shown to be a cause of pica. Pica can be one of many symptoms of distressed, brain-damaged, or retarded children; it can occur in normally intelligent children under various sorts of stress.[35]

The cultural perspective on pica may be even more suggestive. Historian Robert Twyman takes note of a Mississippi study which shows that clay eating continues in the modern South. He interprets the practice as essentially a social habit handed down in the manner of a folk tradition. Not necessarily arising from an insufficient diet or a vitamin or mineral deficiency, clay eating, says Twyman, is presently practiced at all ages, by both sexes, and without regard to race. Disagreeing with Stiles, he believes that "no hard evidence has ever been produced that hookworm causes clay eating."[36]

Treating the Infected

The preliminary Sanitary Commission survey showed heavy hookworm infection (forty to eighty percent of the population) along the sandy coastal plain through eastern Virginia, North Carolina, South Carolina and the southern parts of Georgia, Alabama and Mississippi. Heavy infection in Louisiana was found near the extended Florida state line and in the northern hills. Southern Arkansas and western Tennessee were also heavily infected, even to the Cumberland Mountain plateau.[37]

In 1910 and 1911 the Sanitary Commission put much effort into enlisting the South's 20,000 physicians into "a permanent working force." It published and distributed special bulletins on the diagnosis and treatment of the disease. State directors made personal appeals by letter to each of these doctors. Field workers gave lectures and demonstrations to medical societies and made many visits to practitioners.

So as not to compete with Southern physicians, field workers, upon making a positive microscopic diagnosis, would not administer hookworm treatment themselves but would send the patients to private doctors. Despite the many tactics of courtship however, the Commission's efforts with local physicians proved disappointing. Not atypical of doctors' reaction was that of Dr. J. C. Bramlet of Georgia who complained that the hookworm campaign was "an imposition on my professional rights . . . and a humbug, cheat, and an imposition on the people."[38]

It was soon obvious that a more effective treatment program had to be developed. Many of the people most in need of cure were least able to pay for it. Florida, acting on its own through its public health fund, paid doctors three dollars a case for all cases cured. Some physicians in a few counties of Virginia and North Carolina agreed to give free prescriptions for treatment among the poor; women's associations in these counties supplied the medicine.[39]

In December, 1910, a major innovation appeared in Marion County, Mississippi, as the South's first free dispensary was opened. Funds were appropriated by the county and local physicians provided treatment. Years later, Dr. John Cully, organizer of this dispensary, recalled how he won his appropriation from the Marion County board of supervisors.

> They were not at all inclined to offer any assistance in this work but I had asked for an appropriation of $300 with which to buy thymol and to fit up the little clinic in the office building of Dr. Simmons. (I might add that Dr. Simmons very kindly gave the space to us free of charge.) When the board refused to make the appropriation, I went out and collected specimens of feces from the sons of the members of the board. I placed these specimens in warm containers until the larvae hatched. I then placed these larvae under the microscope which I had set up in the court house and asked each member of the board to look through the microscope. When I assured them that their children were infested with these parasites, they immediately made the donation. I believe the records show that I treated three thousand cases free of charge.[40]

With the spread of dispensaries, the hookworm campaign was adopted into the Southern folk tradition of medicine shows, political rallies, and camp meetings. Typically, a fieldworker would secure a token appropriation from the county government, rally local women's groups and civic organizations, then announce the coming clinic in the newspapers, by handbills, and with posters. On the appointed days, people would arrive early in the morning, walking or riding on wagons from miles away. They would swap hookworm humor, look at exhibits and slides, receive their examination and treatment, then return home to tell their neighbors. Blacks as well as whites were treated.

"The hookworm campaign was adopted into the Southern folk tradition of medicine shows, political rallies, and camp meetings."

Operating at the county level with dispensaries open one day a week at several locations, hundreds of people could be seen each day for six to eight weeks. In the first year of dispensary work, 1911, 74,000 persons were treated in sixty-six counties of nine states. The next year, 150,000 persons in eleven states received dispensary doses of thymol and salts.[41]

State boards of education and schoolteachers were perhaps the Commission's most effective allies. By 1915, instruction on the subjects of hookworm disease and soil pollution was made a part of school courses in eight states. Teachers attended summer institutes, organized lectures and slide shows, and built schoolhouse privies. Fieldworkers used local schoolrooms to set up demonstrations and organize the communities.[42] Years later, South Carolina field director Dr. Francis Bell, remembered the special effectiveness of children:

> In those early days of the fight against hookworm and soil pollution, it was difficult to get an audience of adults to attend a lecture concerning health matters, but the children attended in full force. These young people would carry the message home to the older ones, who would later question me on matters pertaining to sanitation. In this way, I taught the doubting adults thru the children.[43]

The building of sanitary privies did not keep pace with the treatment of the infected. Wickliffe Rose acknowledged in 1912 that "such rapid change in ingrained habit has not been expected."[44] A continuing sanitary survey showed that half of the 250,000 rural houses inspected in 653 Southern counties were without priv-

Privies at Proctor, North Carolina, showing how waste emptied directly into streams. This view is from a bridge on the main street of the small village.

ies of even the most primitive sort in 1915. By means of extensive publicity, the Commission encouraged the building of privies but other than for demonstration purposes, it spent no money on construction.[45]

As public support for the hookworm crusade increased, so did the variety of techniques used to obtain local results. The Hattiesburg, Mississippi, *Tribune* printed a weekly list of the heads of families who had brought their privies up to snuff. "Hookworm Picnic Proves Success" was the title of a Mobile *Register* article which told of a public education meeting whose 700 participants heard a lecture by the state director, saw a series of "before and after thymol" lantern slides, and then broke out their basket lunches.[46]

The Hookworm and Civilization

Under the influence of the Sanitary Commission, the organizations and expenditures of state and county health departments grew rapidly. Especially active hookworm fieldworkers were sometimes invited to stay on as full-time county health officers.[47] The need for health statistics and laboratory testing resulted in the development of other state-supported services. In 1914 the eleven Southern states reported spending $392,364 of their own funds for health departments as compared with $216,195 in 1910 – an eighty-one percent increase. Between 1910 and 1920, legislative appropriations for public health in the South increased more than 500 percent.[48]

Swept away by the accounts of the hookworm crusade as reported in dozens of small-town newspapers and by the field photographs in the Sanitary Commission's files which showed countless sick made well, Walter Page was lost in tides of rhetoric. In a *World's Work* article entitled "The Hookworm and Civilization" (1912), he proclaimed that Dr. Stiles' discovery of the hookworm was "the most helpful event in the history of our Southern states." This parasite, said Page, "has probably played a larger part in our Southern history than slavery or wars or any political dogma or economic creed."

Surely now, Page felt, with the removal of the main cause of Southern backwardness, Ransy Sniffle would stir with "red bloodied life." "Every man who knows the people of the Southern states sees in the results of this work a new epoch in their history and because of its sanitary suggestiveness, a new epoch in our national history."

Envisioning a South restored to the nation and to the grandeur it deserved, Page then moved on to the international scene. After making over the South, the Rockefeller hookworm campaign offered hope for "the re-making of tropical and semi-tropical peoples and the bringing of their lands into the use of civilization as fast as their products are needed."[49] Here was an ambition worthy of a Rockefeller.

As early as 1910, Frederick Gates had asked the Sanitary Commission to collect data on world hookworm infection. In 1913, with Gates' approval, Wickliffe Rose presented a proposal at a trustees' meeting which would use the patterns and methods of the Southern campaign to treat hookworm on a global scale. The International Health Commission was created in June of the same year with Rose as its director.[50] Dr. Stiles, recalling the events of the last year of the Sanitary Commission, remembered Frederick Gates as a man "who always had his telescope focused on all corners of the earth." Stiles felt that the Southern work was not finished. Gates, however, thought the time had come for the Southern states' boards of health to assume the full load of work which had been carried on in their names. "As a result," Stiles writes, "the Commission ended its days." While Page, Rose, Gates and the Rockefellers moved on to pursue the planetary hookworm, Dr. Stiles retired to his laboratory and to his own variety of internationalism, the writing of a book on world parasitic diseases.[51]

In its final report, the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease calculated that its workers had examined a total of 1,300,000 persons in 596 of the South's 1,142 counties. Of those examined, 700,000 had been treated. The average costs of each treatment had been $1.15 for the Commission and $.13 for counties. Perhaps as many as three million infected people were not yet reached.[52]

The original goal of eradication had not been accomplished, yet, in his letter of August 12, 1914, which announced the end of the five-year period for which he had pledged, John D. Rockefeller declared that he was satisfied. By having brought about a general knowledge among Southerners of the prevalence of hookworm disease and of the means of treating and preventing it, "the chief purpose of the Commission may thus be deemed to have been accomplised."[53] Through the International Health Commission, the Rockefeller Foundation continued to fund fifty percent of Southern state and county health costs until 1917, rapidly reducing their support thereafter.[54]

A modern South has not yet seen the eradication of hookworm disease.

It remains, though infrequently, in the coastal plains areas from North Carolina to Mississippi. Like malaria, typhoid and yellow fever, hookworm disease disappeared with the modernizing of the South.[55] Like pellagra, another Southern plague of the early twentieth century, hookworm took its heaviest toll among the poorest and most malnourished people. New diseases, representative of Southern changes, replaced the old. Ransy Sniffle, cured of his intestinal parasites and forced from the farm to the mill village, found newly built privies, but he also found a workplace that mated him with machinery, filled his head with noise and his lungs with fiber dust. Glad to be worm-free, he stood amidst the busy looms and shuttles, imagining only rarely the taste of blackberries and clay. □

Notes

1. Augustus Baldwin Longstreet, *Georgia Scenes* (Augusta: S. R. Sentinel Office, 1835), p. 55.

2. Mark Sullivan, "An Emancipation," *Our Times: The United States 1900-1925*, Vol. III, *Pre-War America* (New York: Charles Scribner's Sons, 1930), pp. 319-323. Charles W. Stiles, *Hookworm Disease in Its Relation to the Negro*, Reprint 36 from Public Health Reports, XXIV, 31 (Washington: US Public Health and Marine Hospital Service, 1909), pp. 3-7. Greer Williams, "The Hookworm Doctors," in *The Plague Killers* (New York: Charles Scribner's Sons, 1969), pp. 7, 19-22.

3. Charles W. Stiles, "Early History, in Part Esoteric, of the Hookworm (Uncinariasis) Campaign in Our Southern United States," *The Journal of Parasitology*, XXV (August, 1939), p. 300. Mary Boccaccio, "Ground Itch and Dew Poison: The Rockefeller Sanitary Commission 1909-1914," *Journal of the History of Medicine and Allied Sciences*, XXVII (January, 1972), p. 81.

4. Williams, p. 4. Sullivan, pp. 299-303. Rockefeller Sanitary Commission, *Hookworm Infection in Foreign Countries* (Washington, DC: Rockefeller Sanitary Commission [hereafter RSC], 1911), pp. 77-85. Rockefeller Foundation, *Annual Report, 1917* (Washington, DC: Rockefeller Foundation), p. 81.

5. Stiles, "Early History of the Hookworm Campaign," pp. 288-289, 291-294. Williams, pp. 10-13.

6. Charles W. Stiles, *Report on the Prevalence and Geographic Distribution of Hookworm in the United States*, Hygienic Laboratory Bulletin No. 10 (Washington: US Public Health and Marine Hospital Service, 1903), pp. 37-53. Stiles, "Early History of the Hookworm Campaign," p. 296.

7. H. F. Harris, "Uncinariasis: Its Frequency and Importance in the Southern States," *Transactions of the Medical Association of Georgia, 1903* (Atlanta: C. Baniston, 1904), p. 352.

8. New York *Sun*, December 5, 1902, p. 1. Boccaccio, p. 34.

9. Study quoted in C. Vann Woodward, *Origins of the New South 1877-1913*, Vol. IX of *A History of the South* (Baton Rouge: LSU Press, 1951), pp. 416-417.

10. Stiles, "Early History of the Hookworm Campaign," p. 296. Sullivan, pp. 290-299, 323.

11. Charles W. Stiles, "Some Recent Investigations into the Prevalence of Hookworm Among Children," *Child Conference for Research and Welfare, Proceedings*, Vol. II (New York: G. E. Stechert and Company, 1910), pp. 211-215.

12. Stiles, "Early History of the Hookworm Campaign," pp. 296-298. Stiles, "Report on the Prevalence and Geographic Distribution of Hookworm," pp. 50-54, 97.

13. Rupert Vance, *Human Geography of the South* (Chapel Hill: UNC Press, 1932), pp. 467-481. See especially Woodward's chapter "The Colonial Economy" in *Origins of the New South*, pp. 291-320.

14. Raymond B. Fosdick, *The Story of the Rockefeller Foundation* (New York: Harper, 1952), pp. 8-9; Allan Nevins, *Study in Power: John D. Rockefeller*, Vol. II (New York: Charles Scribner's Sons, 1953), pp. 314-319. Woodward, pp. 402-404.

15. Woodward, pp. 397-406.

16. Nevins, p. 326. Fosdick, p. 10.

17. Boccaccio, p. 33. Nevins, pp. 302, 326.

18. Stiles, "Early History of the Hookworm Campaign," p. 303. Nevins, p. 326. Williams, pp. 25-26. Minutes of the RSC meeting January 15, 1910; in RSC Collection, Rockefeller Foundation Archives [hereafter RFA].

19. Quoted in Sullivan, p. 327. James Cassedy, "The Germ of Laziness in the South, 1900-1915," *Bulletin of the History of Medicine*, XLV (1971), p. 165.

20. Buttrick speech, December 22, 1925, in Buttrick papers, RFA.

21. Wickliffe Rose, *Report of Administrative Secretary* (Washington: RSC, 1910), pp. 3-5, 31.

22. Wickliffe Rose to Walter Page, October 29, 1910; Page to Rose, November 5, 1910, all in RSC, RFA.

23. Wickliffe Rose to Dr. A.W. Freeman, March 3, 1911, in RSC, RFA.

24. RSC, *State Systems of Public Health* (Washington: RSC, 1910) pp.14-18; Wickliffe Rose to Dr. Morgan Smith, May 12, 1910, RSC, RFA.

25. Smith to Rose, quoted in Boccaccio, p. 44.

26. "Hookworm Conference" in *Journal of the American Medical Associatin*, 1910: Vol. LIV, No. 5, pp. 391-395; No. 6, pp. 484-486; No. 7, pp. 558-560; No. 8, pp. 644-646.

27. Rose to Stiles, May 19, 21, 1910, RSC, RFA.

28. Charles W. Stiles, *Report of Scientific Secretary*, February, 1910, p. 4, RSC, RFA, also Charles W. Stiles, *First Annual Report of Scientific Secretary for the Year Ending January 25, 1911* (Washington: RSC, 1911), p. 19.

29. Stiles, *Hookworm...to the Negro*, pp. 4-6. Stiles, *Report of the Scientific Secretary, 1911*, pp. 19-20.

30. Woodward, pp. 350-351. See George Fredrickson's chapter, "Accomodationist Racism and the Progressive Mentality" in *The Black Image in the White Mind* (New York: Harper & Row, 1971).

31. Marion Hamilton Carter, "The Vampire of the South," *McClure's Magazine*, XXXIII (October, 1909), p. 631.

32. Dr. Charles T. Nesbitt, "The Health Menace of Alien Races," *The World's Work*, XXVIII (November, 1913), pp. 74-75.

33. Frances Maule Bjorkman, "The Cure for Two Million Sick," *The World's Work*, XVIII (May, 1909), p. 11608.

34. Charles W. Stiles, *Soil Pollution as Cause of Ground Itch, Hookworm Disease, and Dirt Eating*, RSC publication No. 1 (Washington: RSC, 1910), p. 22.

35. Joan Bicknell, *Pica: A Childhood Symptom* (London: Butterworth and Co., 1975), pp. 4, 91-94.

36. Robert W. Twyman, "The Clay Eater: A New Look at an Old Southern Enigma," *Journal of Southern History*, XXVII (August, 1971) pp. 443-447.

37. RSC, *Second Annual Report* (Washington: RSC, 1911), pp. 8-9.

38. Rose, *Report of Administrative Secretary*, pp. 11-12. Boccaccio, p. 40. Williams, p. 46.

39. Rose, *Report*, pp. 18-19.

40. Statement of Dr. Cully made May 29, 1939, from Personnel Record, RSC, RFA. The dispensary method had been first used in the early 1900s in Puerto Rico by one of Stiles' students, Bailey K. Ashford. Sullivan, pp. 309-310. Farmer, p. 88.

41. RSC, *Second Annual Report*, p. 24; RSC, *Fifth Annual Report* (Washington: RSC, 1915), pp. 22-23.

42. RSC, *Third Annual Report*, p. 24; RSC, *Fifth Annual Report* (Washington: RSC, 1915), pp. 22-23.

43. Statement of Dr. Bell made February 10, 1939, from Personnel Record, RSC, RFA.

44. RSC, *Third Annual Report*, p. 19.

45. RSC, *Fifth Annual Report*, p. 13-14.

46. Rockefeller Foundation, *Annual Report, 1916*, p. 81-82; RSC, *Fifth Annual Report*, pp. 23-24.

47. See Statement of Dr. Carl Grote, January 21, 1939, Personnel Records of RSC, RFA.

48. H.F. Farmer, *The Hookworm Eradication Program in the South, 1909-1925*, PhD Dissertation, 1970 (Ann Arbor: University Microfilms, 1972), pp. 113, 121. RSC, *Fifth Annual Report*, p. 26.

49. Walter Page, "The Hookworm and Civilization," *The World's Work*, XXIV (September, 1912), pp. 504, 509, 518.

50. Williams, pp. 51-52.

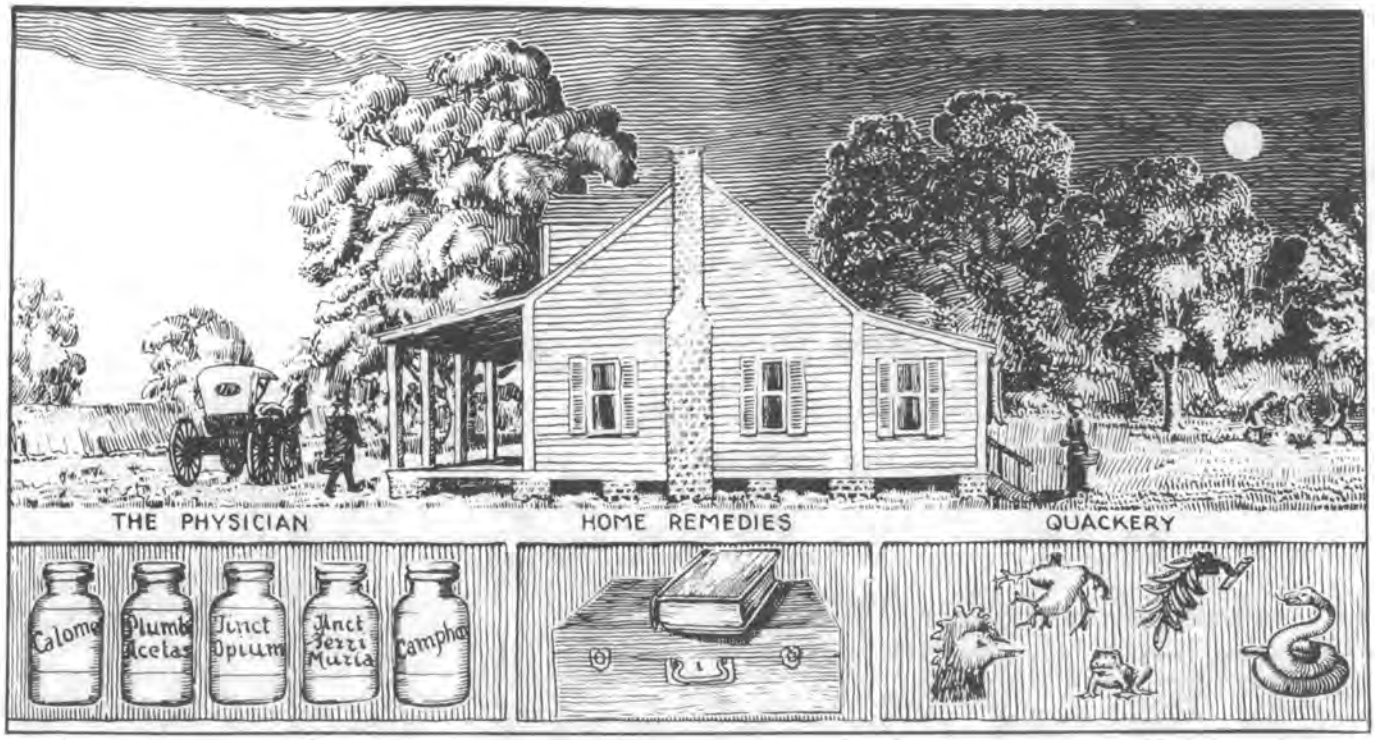
51. Stiles, "Early History of the Hookworm Campaign," pp. 304, 306. Sullivan, pp. 331-332. E. Richard Brown, "Public Health in Imperialism: Early Programs at Home and Abroad," *American Journal of Public Health*, LXVI, 9 (September, 1976), pp. 879-903.

52. RSC, *Fifth Annual Report*, pp. 17, 37, 43; Williams, p. 47.

53. RSC, *Fifth Annual Report*, pp. 26-27.

54. Rockefeller Foundation, *Annual Report, 1916*, pp. 89-90; Farmer, p. 118.

55. Williams, pp. 94-95.



People's Medicine in the Early South

by Peter Wood

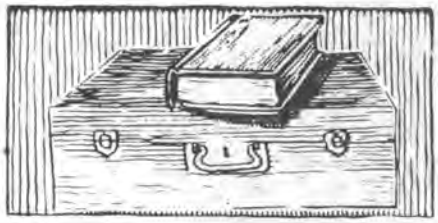
In 1951, when William Postell published a brief study of *The Health of Slaves on Southern Plantations*, the frontispiece conveyed a curious message. The print suggested that residents of rural cabins, where good health rested firmly upon the family Bible and the home medicine chest, had two outside alternatives in times of sickness. At the back door a "black mammy," labeled QUACKERY, waited with her witch-like charms while her kinfolk danced Indian-fashion around a moonlit campfire. At the front door, meanwhile, appeared THE PHYSICIAN, carrying the latest in bottled drugs. So that no one would have any doubts about the preferable way to turn, the professional doctor was bathed in sunlight and his non-professional counterpart was wrapped in darkness.

The allegorical picture by a "medical artist" dramatically illustrates widely held assumptions about the evolution of Southern medical care. The history of health in the South is often told in terms of modern medicine's giant leaps forward – the first use of ether for anesthesia in Georgia, the campaign of the Southern Health Board to eradicate hookworm, the completion of successful heart transplants in Texas – all landmarks that have been achieved, and memorialized, by white male doctors. And nowadays such triumphs are often linked to the prestigious medical schools and modern hospitals, both public and private, that have grown up from Baltimore to Houston. Indeed, over the past century these powerful scientific-commercial institutions have extended the system of modern medicine so pervasively throughout the South that it is difficult to recall, much less comprehend, the alternative health care traditions that once predominated.

But those traditions existed in the South. Nowhere else in the country did patterns of "pre-modern" health treatment derive from such diverse sources, develop so fully, and endure so long. Even now these patterns, woven from the knowledge of Native Americans, Africans and Europeans, are not entirely dead in parts of the rural South. And they are of more than nostalgic interest in an era when medical values appear selfish and warped, when the human and financial costs of medical care seem absurdly high, and when the medical establishment acts more concerned with public relations than with public health.

While the eighteenth-century realm of purgatives and balms is now remote, some of its underlying principles have an enduring appeal. As scientific-medicine-for-private-profit begins to appear something less than total enlightenment and sunshine, we can begin to ask whether traditional health care was entirely superstition and darkness. The answer bears little relation to Postell's frontispiece. Long before the white scientist walked in the front door, Southerners of all races benefited from health care which, whatever its limitations, gave primary attention to patients, relied heavily on low-cost and easily obtainable herbal remedies, and was available on a comparatively equal basis to all.

Peter Wood teaches history at Duke University and is the author of Black Majority.



Hominy, Herbs and Healers

When non-Americans first reached the western hemisphere, they found that in many regions the native people, growing the unfamiliar crop known as maize, were obtaining a higher yield of food per acre than farmers in the Old World. As Europeans and Africans took up maize cultivation, they began to suffer from the niacin deficiency known as pellagra. Historian William McNeill points out that the Amerindians had "escaped pellagra by soaking maize to make 'hominy grits,' and by supplementing their diet with beans in those regions where hunting was no longer possible." He explains that maize kernels "were soaked in a lime solution, which broke down some of the molecules . . . in a way that allowed human digestion to synthesize needed vitamins that are absent from the maize itself." Gradually this special preparation of corn, which offset its nutritional disadvantages, passed into non-Indian, Southern culture. Archaeologists can still point out the well-worn "hominy holes" in ancient rock formations where regional tribes first evolved the recipe for grits.

Indian skill with domesticated crops was more than equaled by their knowledge of wild plants. When John Hawkins, the English sea captain, touched the Florida coast in 1565, he noted that the inhabitants "have for apothecary herbs, trees, roots and gummes...whereof I know not the names." Hawkins did not stay, but Frenchmen settling there at the same time told Spaniards arriving a decade later that "when thei came into those partes, thei had been sicke the moste of theim, of greevous and variable diseases, and that the Indians did showe them this Tree, and the maner how thei should use it, and so thei did, and thei healed of many evilles." The tree was sassafras, and soon the Spaniards were using it with such "greate effects, that it is almost incredible."

When English settlers entered the deep South more than a century later, they complained that earlier Europeans had not paid close enough attention to Indian medicine. "Amongst all the Discoveries of America by the Missionaries of the French and the Spaniards," wrote John Lawson of North Carolina in the early eighteenth century, "I wonder none of them was so kind to the World as to have kept a Catalogue of the Distempers they found the Savages capable of curing, and their Method of Cure . . . . Authors generally tell us that the Savages are well enough acquainted with those Plants which their Climate affords, and that some of them effect great Cures, but by what Means and in what Form, we are left in the dark."

The English tried to be more observant of Indian practices. John Brickell (who borrowed much of his data from Lawson) stated that the natives could "perform notable Cures, of which it may not be amiss to give some Instances, because they seem strange, if compared with our Method of curing Distempers." He reported that while they gathered plants, leaves and tree bark from the countryside, they also cultivated special gardens of medicinal herbs, "that upon all Occasions they might be provided with these vegetables that are proper for the Indian Distempers, or any other use they might have occasion to make of them."

Thomas Ashe, a late seventeenth-century English observer in Carolina, commented that the natives' "exquisite Knowledge" was "conveyed in a continued Line from one Generation to another, for which those skill'd in this Faculty are held in great Veneration and Esteem." This statement was confirmed in the next century by John Wesley, the famous evangelist who preached in the fledgling colony of Georgia in the late 1730s. In his hugely popular book on *Primitive Physic*, first published in 1747, he observed of the Indians that, "if any are sick, or bit by a serpent, or torn by a wild beast, the fathers immediately tell their children what remedy to apply. And it is rare that the patient suffers long; those medicines being quick, as well as generally infallible."

This praise was not based on hearsay; many whites had direct experience of Indian medical skills. In 1725, Alexander Long recorded being cured by "the greatest herbalist that ever I saw in all my life" while among the Cherokee. During the same decade Le Page du Pratz, a Frenchman who lived among the Natchez in Louisiana, told of a crippling and persistent pain in his thigh. White physicians in New Orleans bled him, suggested aromatic baths, and advised him that he should return to France "to drink the waters." But his field hands urged him to consult the Natchez, "who, they said, did surprizing cures, of which they told me many instances, confirmed by creditable people." When the Indians prescribed the application of a simple poultice, he was up and about within eight days, and the pain never returned.

Indian skill with domesticated crops was more than equalled by their knowledge of wild plants.

From this point on, du Pratz was deeply respectful of Indian medical knowledge and conscious of European ignorance. Of several field plants he wrote, "The native physicians know more of its virtues than we do in France." And in describing the so-called copalm tree, he stated, "I shall not undertake to particularize all the virtues of this Sweet-Gum or Liquid-Ambar, not having learned all of them from the natives of the country, who would be no less surprised to find that we used it only as a varnish, than they were to see our surgeons bleed their patients."

Not long after his first sickness, du Pratz developed an eye infection, and a Paris-trained surgeon in Louisiana advised him it would be "necessary to use the fire for it." Before the Frenchman consented to the crude technique of cauterizing, he was visited by the friendly Natchez chief. "The Great Sun observed I had a swelling in my eye," du Pratz recalled, "and asked me what was the matter with it. I shewed it to him, and told him that in order to cure it, I must have fire put to it; but that I had some difficulty to comply, as I dreaded the consequences of such an operation." Without replying, the chief summoned his doctor, who examined the eye and cured it perfectly in a matter of days. "It is easy from this relation to understand what dextrous physicians the natives of Louisiana are," du Pratz concluded. "I have seen them perform surprising cures on Frenchmen."

Cherry Bark, Ginseng and Snake Root

Afro-Americans were also capable of surprising cures. "The slave," writes French scholar Frederic Mauro, "brought with him his cooking practices, his sense of a balanced diet adapted to the tropics, of medical formulas and of plants unknown in America." Though Europeans benefited directly and indirectly from this tradition, they were generally unwilling to acknowledge and examine it. It was exceptional for Janet Schaw, touring the South in the eighteenth century, to note in her diary, "The Negroes are the only people that seem to pay any attention to the various uses that the wild vegetables may be put to."

Some of this knowledge came from local Indians, with whom blacks had close contact during the early years of foreign settlement; some came in from the old country. A former slave woman interviewed in Texas in the 1930s claimed that her mother had learned knowledge of herbs from the Indians and from "old folks from Africy."

"My old granny uster make tea out o' dogwood bark an' give it to us chillun when we have a cold," recalled Fannie Moore, an ex-slave from North Carolina. "Else she make a tea outen wild cherry bark, pennyroil, or hoarhound. For stomach ache she give us snake root. When you hab de fever she wrap you in cabbage leaves or ginseng leaves; dis made de fever go." According to Solomon Caldwell of South Carolina, "I 'member my ma would take fever grass and boil it to tea and have us drink it to keep de fever away. She used branch elder twigs and dogwood berries for chills."

Many of these treatments were complex and effective, and those who could practice them best were often known as "doctor." Even when whites were officially in charge of plantation health, black midwives played a significant role. A white doctor among the South Carolina planters observed, "On every plantation the sick nurse, or doctor woman, is usually the most intelligent female on the place; and she has full authority under the physician, over the sick." In 1729, a Virginia slave named James Papaw was granted freedom and a thirty pound a year pension for life when he agreed to make public a complicated "decoction of the woods," said to be effective against yaws and "the most inveterate Venereal Distempers." Several decades later in South Carolina a man named Sampson, enslaved to Mr. Robert Hume, received his freedom and a one hundred pound pension for revealing his elaborate remedy for rattlesnake poison.

But useful knowledge of herbs and medicines did not always suit the planters' interests, for enslaved workers often made use of these skills in the struggle for independence and liberation. South Carolina slaves regularly induced abortion by boiling four ounces of root bark from the common cotton plant in a quart of water until it was reduced to a pint, then drinking a dose two or three times per hour. The process proved so effective that a white doctor in Georgia eventually publicized his own decoction of witch-hazel leaves to prevent the abortions which the blacks freely induced.

Of greater concern to Caucasians was the constant threat of poisoning. In the mid-eighteenth century, South Carolina's noted doctor-botanist, Alexander Garden, troubled by the skills in the hands of "negroe Strollers and old women," set out to "investigate the nature of particular poisons (chiefly those indigenous in this province and Africa)." He asked experienced friends to give him what information they could "about African Poisons, as I greatly . . . suspect that the Negroes bring their knowledge of the poisonous plants, which they use here, with them from their own country."

Several years later, in 1751, a rash of suspected poisonings had led South Carolina legislators to pass a law designed to curtail black knowledge about, and access to, medicinal drugs. The act stated that "in case any slave shall teach or instruct another slave in the knowledge of any poisonous root, plant, herb, or other poison whatsoever, he or she shall suffer death as a felon." It was made unlawful for white physicians "to employ any slave or slaves in the shops or places where they keep their medicines or drugs," and up to fifty lashes were prescribed for any "negroes or other slaves (commonly called doctors)" who attempted "to administer any medicine, or pretended medicine, to any other slave; but at the instance or by the direction of some white person." Similar harsh laws prohibiting the exercise of black medical knowledge spread throughout the slave South over the following century and had an inevitable effect on limiting the use of Afro-American skills. But the re-enactment of such laws suggests that none of them were entirely successful in their purpose. In 1844 a Tennessee court, ruling on the case of a respected black healer named Jack, observed that "such doctors might foment insurrection" and declared that "it was thought most safe to prohibit slaves from practicing medicine altogether."

Hesitantly, Europeans in the South learned to take advantage of these alternative traditions and the plants upon which they were based. New and effective remedies were often sent back to the Old World. In 1745, for example, the *London Magazine* mentioned the use of Virginia snake root in a preparation for the plague. A century later, James W. Mahoney of North Carolina published an entire

THE GREATEST HERBALIST

This relation that I had of the screech owl was from one of the greatest Indian doctors and the greatest herbalist that ever I saw in all my life, I myself being cured by him of sore eyes.

I was in such a miserable condition that I was so blind that I could not see above ten paces from me. I sent for this great doctor and asked him if he could cure me and he come close to me and looked on me and said why did you not send for me when you was first took with it? You should not have suffered so much as you have done. Nevertheless by the morrow this time you shall be cured. He went out and went down to the river side and brought with him an herb and bruised it and dropped the juice thereof in my eyes. As soon as the juice touched my eyes, I found ease and the next morning I was quite well and found no manner of pain and could see a mountain that was distant from me 3 miles very plain.

—Alexander Long, "A Small Postscript on the ways and manners of the Indians called Cherokees", 1725.

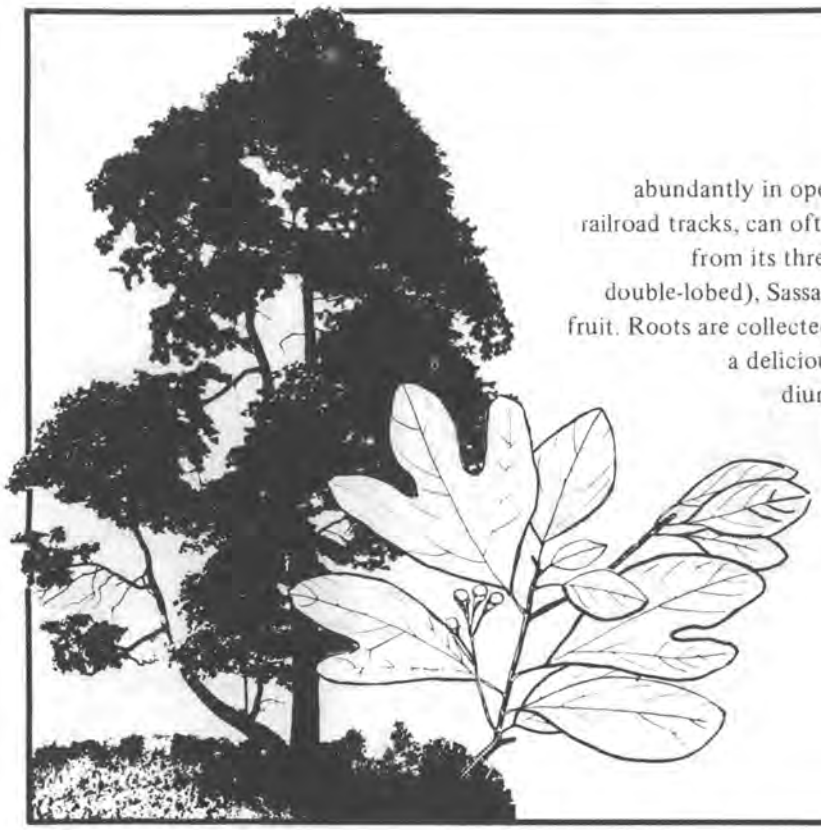
volume entitled, *The Cherokee Physician, or Indian Guide to Health* (Asheville, 1849). Virgil J. Vogel, author of *American Indian Medicine*, noted recently, "Perhaps the most celebrated remedy to reach the world by way of the Carolinas was the Indian pinkroot (*Spigelia Marilandica* L.), a Cherokee remedy for worms, which was adopted into the London, Dublin, and Edinburgh pharmacopeias, and was official in the American pharmacopeia from 1820 to 1926." At first Europeans were less familiar than Indians and Africans with the semi-tropical flora of the deep South. And as time passed, health care among whites was moving slowly out of the hands of parents, ministers and midwives into the hands of paid apothecaries and surgeons. But these facts did not prevent European immigrants from importing their own substantial knowledge of traditional medicine or from exchanging, enriching and expanding these skills in the New World.

By the nineteenth century, white Southerners regularly publicized established treatments as well as new ones. For example, John S. Wilson, a physician from Columbus, Georgia, who had practiced in south Alabama, published articles in the *American Cotton Planter* and edited a "Health Department" for *Godey's Lady's Book* during the 1850s. He was at work on a book called *The Plantation and Family Physician* when the Civil War broke out, and in 1863, while serving as a Confederate Army surgeon, he published a sixteen-page booklet entitled *The Southern Soldier's Health Guide*. Nothing illustrates the persistence of traditional medicine in the region better than the fact that during that same year, the Surgeon General's Office of the Confederacy in Richmond issued a "Standard Supply Table of the Indigenous Remedies for Field Service and the Sick in General Hospitals." Confederate soldiers were reminded that, "The interests of the government which they serve, and the importance of relying upon the internal resources of their own country, should prompt the adopting as far as practicable, of these remedies as substitutes for articles which can now be obtained only by importation."

The motivation for self-sufficiency in health care, both regional and individual, dwindled away in the South during the century after the Civil War. Slowly, medical treatment by professional, scientific doctors became more commonplace and pervasive; methods of self-help were increasingly frowned upon, prohibited or forgotten. But the principles behind Southern traditional medicine never quite died out, and now, in the face of a highly institutionalized, bureaucratized and unresponsive modern health system, they are taking on renewed life.

Health care moved slowly out of the hands of parents, ministers and midwives.

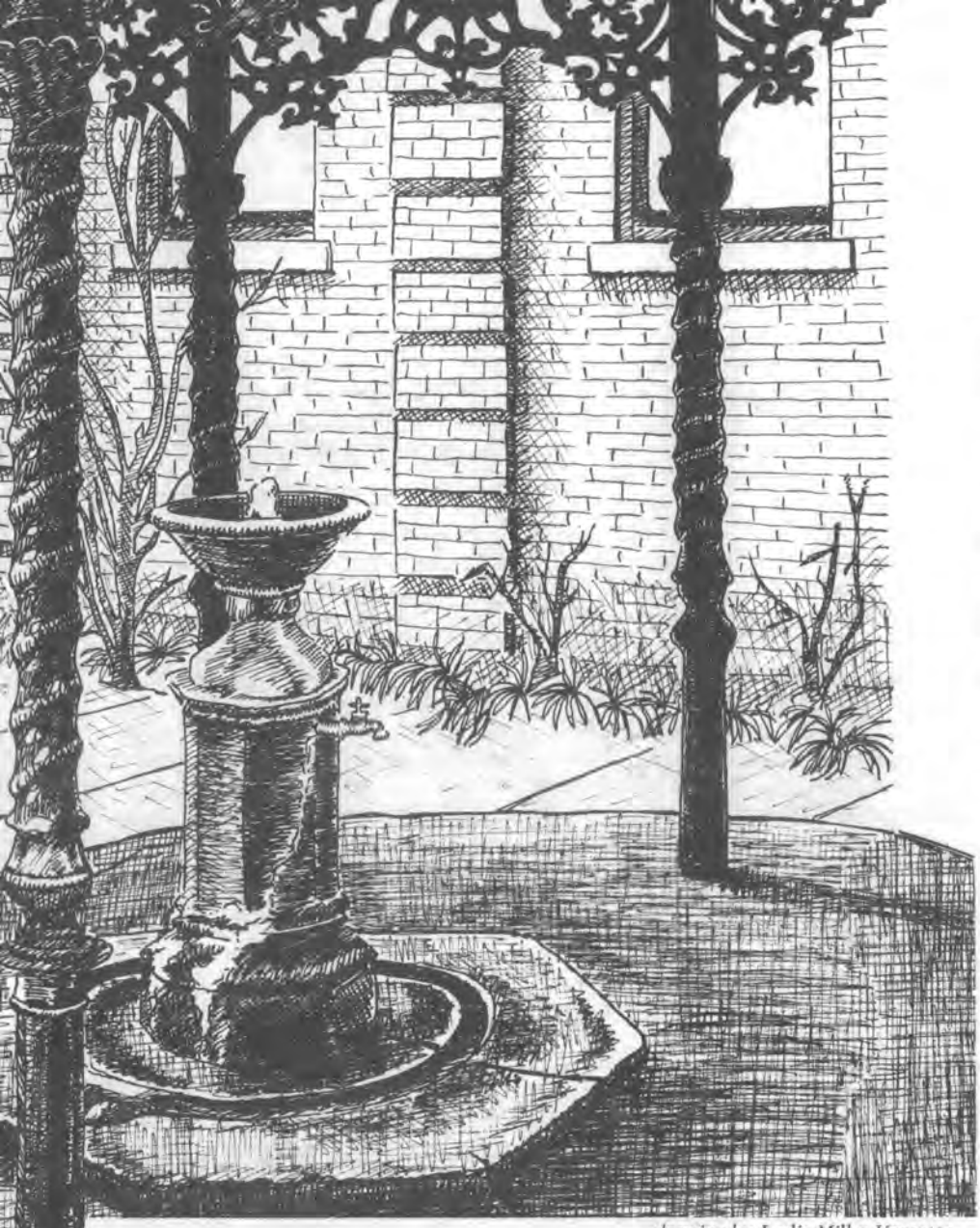
Imagine a time when healers give individualized attention to the sick, understanding the need to treat a specific illness as part of the whole person and to view each individual as part of a community. Consider a place where simple and organic treatments are applied with the smallest expense and the least bureaucracy possible. Conceive a society where no yawning chasm exists between the care purchased by a few and the care received by all. If these conditions prevailed in the early South to an unrecognized degree, there may well be a place for such principles of traditional medicine again somewhere in the future of the region. □



Sassafras *(sassafras albidum)*

a Southern tree or shrub which grows abundantly in open woods, deserted fields, along fence rows and railroad tracks, can often reach ninety feet in height. Easily identified from its three distinct leaf shapes (oval, mitten-shaped, and double-lobed), Sassafras has yellow flowers in spring and small blue fruit. Roots are collected in the spring and fall; when boiled they make a delicious orange-colored tea, considered a stimulant, a diuretic and a treatment for stomach gas and colic. The tea is also ritually drunk as a spring tonic and blood purifier, and can be used as a poison ivy wash. Sassafras leaves are an essential ingredient in Creole cooking, and Louisiana families often keep a shaker of dried leaves on the table to add to soups and stews.

— **Leaf Diamant**



drawing by Leslie Miller Vorgetts

Healing

I don't put a lot of faith in doctors and medicines and hospitals. I don't know many people who do. We all use them, but often it seems only as an absolute last resort, after all else fails. This is nothing new, of course, and may even be inevitable for a field whose professionals seem to bank on the ignorance of their patients. Rather than let a stranger handle our bodies, or stick strange instruments and chemicals in them, we do what we can, in our own ways.

Except in emergencies, we count on various sure-fire home remedies that we've come across and found successful. I use hot teas and Vitamin C, rest and exercise, good Scotch, massage. I have a friend who fasts every time his temperature wiggles, and another who stuffs herself with a grand dinner at the first sign of illness. We all stand by our cures. It doesn't seem to matter what one chooses; it's the belief in a remedy that counts.

I now add healing waters to my list of cures. I believe in waters. They have cured people for a couple hundred years in this country, and centuries before that around the world, and they can damn well cure me, too.

Throughout the South, many people still depend on healing waters. In almost every state, artesian wells and mineral springs can be found that have been used for drinking and bathing illnesses away. In the mountains, thermal springs – bubbling up heated from underground, usually of volcanic origin – have drawn great attention for their medicinal qualities. In other areas, waters from unexpected sources – or transformed by unexpected forces – have become known for their curative powers, and have attracted health seekers from throughout the world.

Wherever one finds the healing waters, testimonials abound. The waters have cured everything from diarrhea to cancer. People swear by them and bring their friends. They write glowing accounts of them, and judging by their claims, the waters work.

But healing waters are like every other resource in America: when they become popular, people try to take them over and make a buck. The waters are bottled, promoted. They become the site of spas, hotels, medical centers, of railroad stations and airports. They are restricted to use by a very few, or they are polluted. The task of protecting and using healing waters then ceases to be just a folk health issue and becomes one of land use, of division and use of wealth.

"A Healthful Drink"

Charleston, South Carolina, where I live, was once filled with artesian wells. The wells provided about half the water for the city, the rest coming from cisterns. Every couple days, the people of the city gathered up their jugs and headed to their nearest or favorite well. There they met their friends, asked about each other's health, and exchanged news and gossip. They were just being sociable, and got free water to boot.

But there were other benefits as well. In the city yearbook for 1881, a Scientific Committee, established to report on the history of the city's wells and the quality of the water, announced:

"As a drink it is healthful. There is

Steve Hoffius is a Charleston, South Carolina, bookseller and free-lance writer.

Waters

by Steve Hoffius

no deleterious ingredient in it. The habitual use of the water of the Wentworth Street well was known to be very beneficial in dyspepsia and kindred diseases . . . .

"For culinary purposes it must be equally healthful . . . .

"For bathing no water can be more delightful. For washing and cleansing clothes, it is far superior to the ordinary well water and even to cistern water."

Nearly everyone in the city counted on that water at some time. Business houses sent employees for water to offer their customers and clients. Doctors recommended it for illnesses. The only hesitation concerned its use for cooking rice, a staple of the Charleston diet. Artesian well water seemed to turn the rice a strange color, either "golden" or "dirty," depending on whom one spoke to.

The city's fire station was eventually built by the Wentworth Street well. Today the well is one of only two left in the city, and it produces a steady flow of water, from both a faucet and a drinking spout. Many people come to use the water regularly, or bring plastic containers to take it home.

One day when I stopped for a drink (a safeguard against some of those "kindred diseases"), I spoke with a woman preparing to visit her brother in North Carolina. She was filling about a half dozen five-gallon containers with water, as a present for him. "He's been there three years now," she said, "but he still don't like the water. Any time somebody goes up to see him, we have to take as much water as we can manage." She said she had come to the well for as long as she could remember, and her mother had, too.

According to regular users, the water is good for most any ailment, including digestive problems, muscle pains, skin rashes. Even tooth decay. In Charleston, the wells are the only ways to get any fluoride for one's teeth. In 1956, when the country was battling over the question of whether fluoride-treated water was a Communist plot, Charlestonians found a unique way to sneak around the issue. The Parker Laboratories analyzed the artesian well water and announced that included four times the amount of sodium fluoride recommended to fight cavities. That made the fluoride appear less threatening, but it also made it an unnecessary addition to the city's tap water. A local newspaper proposed that residents who wished the benefits of fluoride might simply keep a jug of well water by their bathroom sink and mix it with three parts tap water when they brushed their teeth.

The people of Charleston go to their artesian wells for many reasons, but more for the taste, the inexpensiveness and the feeling of gathering their own water, than for its curative powers. Just one hundred miles away, however, stands a spring whose popularity is based almost solely on its reputation for healthfulness: Healing Springs, just outside Blackville, South Carolina.

Healing Springs of Blackville

When white settlers first "discovered" the springs, they found the Indians there were already familiar with the special qualities of the water. Even then, it was called Healing Springs. According to legend, before whites arrived, it had rarely been used for casual drinking or bathing. It was a ceremonial pool, used only for religious purposes. During the Revolutionary War, a band of British soldiers stopped at the spring to reconnoiter for fresh water, and when they moved on, left several of their party there to recover from injuries. They are said to have regained their strength so quickly that they soon overtook the others.

For centuries everyone in the area understood the spring to have healing qualities; it was their local health center, and they rarely questioned its powers. Occasionally some businessman would devise a scheme to develop the area, to capture the springs for personal use, or to take financial advantage of the waters. Around 1900 the spring kept a small bottling plant in operation. Lute Boylston, who inherited the land on which the spring was located, wrote of the entrepreneurs (including his ancestors) in his will when he noted:

"It is historically true that the Indians who once possess the land and waters regarded it as a healing gift to them from the great Spirit, but I do not believe the white people who dispossessed the Indians ever appreciate the value . . . for several white people have tried to destroy the said well during the time I have owned it."

To make sure the waters remained in public use forever, Boylston willed "the most treasured piece of this earth that I have ever owned" to "Almighty God . . . for the public use, especially for the diseased or affected to the use of the precious healing waters that flows from this God-given source."

Boylston wrote his will in 1944 and died in 1953. Before long the area became a garbage dump. When Jeanniene Ross moved to town twenty-two years ago, the spring could not be seen from the road and was surrounded by "car radiators and washing machines and abandoned cars and dead dogs and people's garbage." She and another local woman, Ruth Browning, took responsibility for

the springs' improvement and, often alone, they cleaned up the area, built a parking lot, put the springs' pipes in working order, and placed a picnic table, garbage cans, shrubs and lighting around it. They finished their work in 1970, in time for the state's Tricentennial, and since then Healing Springs has been known to draw 1,000 people a day, making it a more popular attraction than many state parks.

Among those who visit, explains Ross, is the family of an Atlanta woman; they arrive every month in a truck filled with plastic jugs. The woman, now in her eighties, was cured more than sixty years ago of a rare skin disease that doctors said was beyond relief. A Blackville physician, unable to help with his own medicines, suggested Healing Springs and after thrice daily bathings in the water, she recovered. She has drunk Healing Springs water ever since. Ross reports that a local man, who had been a preacher in the North for many years, returned home not long ago after developing severe cataracts. He was convinced that his vision was almost lost, and that his effectiveness in the church would soon end. After using the waters, his vision returned and he now serves as preacher at four area churches. People regularly come to Blackville from Charlotte, Charleston, Columbia, Atlanta and beyond. Says one local woman, "It's the biggest thing that ever hit this town."

Throughout the South, this story is repeated.

In Kentucky, for instance, the foothills are filled with mineral springs, where animals once licked salt, and hunters and farmers sought cures for all their ailments. Eventually these grew into eastern Kentucky's large health resorts, including such spots as Olympia Springs in what is now Bath County, Swango Springs in Wolfe County, and Blue Lick Springs in Nicholas County. Hotels were established, facilities for entertainment provided. As the springs drew more and more people, and richer people, the focus became increasingly social, no longer medical. Doctors who would recommend the water for most anything were still employed by the hotel proprietors, but bottled liquids became more popular than tubsful. The evening ball attracted more people than the morning bath.

Boylston willed the Blackville springs as "the most treasured piece of earth. . . ."

No mere mineral spings, however, could compare with the health claims of the South's thermal springs, primarily found in Virginia, West Virginia, Georgia, and Arkansas. Nor with the resorts that quickly took them over.

Mineral springs and artesian wells were special pools of water. They smelled and tasted differently from most water, and people attributed great healing qualities to them. But thermal springs! Ah, now there is a wonder to behold. Imagine coming upon one in the wilderness a couple hundred years ago. Many smell strongly of sulphur. Not just so that when you stick your nose next to it you are aware of the aroma; they reek. For a hundred yards they reek. And they bubble. And steam. But when you see a thermal spring before you – a hot bath, a whirlpool, everything you need but a towel – you endure the smell (and sometimes it isn't quite that bad; sometimes) and you relax all your sorrows away, as the water bubbles up around you and over you, wiping away pain, soothing tired muscles, providing some sexual stimulus.

Before European settlers arrived, the thermal springs of the Southern mountains were already popular. The Indians used them regularly, establishing a pact that the pools and the good hunting grounds nearby would be a sanctuary for all tribes.

Wilderness Whirlpools

By the middle 1700s white settlers had discovered the thermal springs of Virginia. In 1750 a visitor to Hot Springs, Virginia, wrote, "We visited the hot spring and found six invalids there. The spring is very clear and warmer than new milk." Five years later, a primitive hotel was built. It was one of the few hotels in the Virginia mountains and was soon crowded with travelers. In the surrounding miles, other hot springs were soon found with different qualities. They varied in their chemical makeup, in their temperatures (some as high as 100°, others less than 65°), in their surroundings, and they gained their names from these differences: the Old Warm and Little Warm (later called the Hot) Springs, the Sweet Springs, the Red Sulphur, Salt Sulphur, Blue Sulphur, Gray Sulphur and Yellow Sulphur Springs, as well as the Montgomery White Sulphur, the Fauquiet White Sulphur and the Jordan White Sulphur Springs.

As the number of persons healed increased, the fame of the waters spread. In 1778 the first white settler, Mrs. John Anderson, stayed for an extended visit at a spring to the southwest of many of the others, eventually called the White Sulphur Springs in what is now West Virginia. She was cured of her chronic rheumatism and other health seekers soon followed. One Philadelphia writer claimed, "the water has the pleasant flavor of a half-boiled, half-spoiled egg . . . . It is very beautiful and tempting and cures the following diseases, according to popular belief – Yellow Jaundice, White Swelling, Blue Devils and Black Plague; Scarlet Fever, Yellow Fever, Spotted Fever and the fevers of every kind and color; Hydrocephalas, Hydrothorax, Hydrocele and Hydrophobia, Hypochondria and Hypocrisy; Dyspepsia, Diarrhoea, Diabetes, and die-of-anything; Gout, Gormandising, and Grogging; Liver Complaint, Cholic, Stone, Gravel, and all other diseases and bad habits, except chewing, smoking, spitting and swearing."

The visitors came, and in 1811 ten cottages were built at White Sulphur Springs to house them all. These were quickly filled, and people had to be put up in local farmhouses. A springhouse was established in 1817. Soon a second was built, with eight tall pillars and a statue of Hygeia, the goddess of health, atop it. In 1817 Henry Clay, who traveled regularly between Kentucky and Washington, DC, stopped for his first visit, and the boom began.

Where Clay went, other politicians and businessmen followed, discussing the major issues of the day with him, gossiping and jockeying for attention. They brought their wives and children, who established their own routines of socializing.

In 1858 the Grand Central Hotel, called The White, opened in White Sulphur Springs, a remarkable sight in what was then still frontier land. It featured three floors and a basement, including 228 rooms. Newspapers claimed a guest capacity for The White of 1,000 to 1,500. At one time up to 5,000 people were said to have been crammed into the structure. It quickly became the leading vacation spot for the rich from miles around. From Tidewater Virginia and Maryland, Low Country Carolina, Alabama and up into Kentucky, once hot weather arrived, or an epidemic broke out, or a slave revolt seemed too threatening, the rich climbed into their carriages and took off for what often consisted of a many-month vacation.

The various springs vied with each other for customers, but the White Sulphur Springs hotel, soon called the "Old" White, and nearby Hot Springs with its Homestead Hotel, outdrew the others and joined the lists of the leading east coast resorts. Wealthy visitors came from Philadelphia and Boston, from England.

To draw these people, the Old White developed a number of activities. Every night, for instance, the hotel featured The Treadmill, a stately promenade reportedly first established when Henry Clay offered his arm to Mrs. John Preston after dinner and led her about the huge uncarpeted space of the parlor. John C. Calhoun followed Clay, taking the arm of a Mrs. Rhett, and the entire dinner gathering followed behind. Soon every evening's meal was completed with this march about the premises.

Old White bartenders sought to outdo each other with new drinks, and in 1858 the first mint julep was supposedly mixed there, containing French brandy, old-fashioned cut loaf sugar, limestone water, crushed ice, and young, home-grown mountain mint.

The Virginia thermal springs quickly gained a reputation as prime breeding grounds for young belles and gentry, and many of the wealthy

The various springs vied with each other for customers, but the White Sulphur Springs hotel, soon called the "Old White," outdrew the others as a classy resort.

visited simply so their children could court in style. The Old White established a busy routine for them, with the token spring-drinking before breakfast, champagne-and-watermelon lawn parties at noon, and parties concerts and a ball later in the day.

The balls themselves gained great fame for the new dances, or figures, that were popularized. "The most famous figures," reports one historian, "were the Butterfly, in which the belles fluttered about the ballroom waving large wings of chiffon and pursued by beaux with long-handled butterfly nets, and the Coach-and Four, in which the beaux literally drove the belles around the ballroom—harnessed four abreast and covered with jingling ornaments."

With such features, the White Sulphur Springs was clearly The Place To Be, though its popularity was contested by the Hot Springs Homestead Hotel, where local waiters balanced trays of food on their heads and then danced frantically to the cheers and applause of the diners.

Still, reports of the springs were not always favorable. One guest wrote that the meals featured, "the cursing of bread, abominating the butter, detesting the coffee, disliking the tea, scolding the servants, then the galopping consumption of mutton, the clashing of knives and forks, the trotting of negroes, the forlorn looks of those neglected, and the self satisfied air of those who are provided with private dishes."

The Civil War, of course, was rather tough on the resorts (White Sulphur Springs and the Homestead were used as hospitals), and people began to fear for their future. In 1867, however, Gen. Robert E. Lee, mounted as always on Traveller, came riding to the rescue. His wife was ailing, and she had been advised to visit a thermal spring to improve her health. The Lees chose White Sulphur Springs, both for the quality of the waters and accomodations and, it is said, for its location. Lee supposedly felt that in the recently-established state of West Virginia he could do his share in mending the wounds of the war, by bringing together vacationers from both regions. Every summer until 1870 the Lees stayed at the springs, visiting – as hoped – with both Northerners and Southerners, and providing historians the opportunity to talk of the springs "healing the war-torn nation as it did the bodies of its visitors."

Eventually, though, even the life at the resorts had to change. In the 1890s the C&O Railroad, which controlled much of the transportation to the springs, bought White Sulphur Springs, and encouraged vacationers other than the very rich to sample the accomodations. Old-timers were shocked. During the Second World War, the government first used the White Sulphur's hotel as a hospital and then as an internment camp for

foreign diplomats and newspaper correspondents. In 1945 the C&O bought back the building, reconverted it to a spa, and opened it in 1948. With increasing numbers of families owning automobiles and possessing sufficient money to go away for trips, even more Americans visited these healing waters.

The springs' oldest and most loyal supporters groused about the low quality of vacationers. "In the old days," remembers Colonel McKee Dunn in Cleveland Amory's *The Last Resorts*, published in 1952, "we had everybody. We had Vanderbilts and Whitneys and we had Mr. Stuyvesant Fish and Governor Livingston Beeckman from Newport and we even had a Miss Postlethwaite from Boston – oodles of people like that. Now we don't have anybody. Everything has gone to hell in the last twenty years. Roosevelt and Truman and all those people have given everybody the idea that they're just as good as everybody else."

Now the White Sulphur Springs are part of a large health complex, where guests – paying up to $140 a day for double accomodations and two meals–can purchase an hour treatment that might include a mineral springs bath, sauna, massage, steam and scotch spray for $15.

The springs, still used for medicinal purposes, are almost inseparable from the resort that took them over. They have become just another feature, listed in the same breath with the series of indoor-outdoor tennis courts or the championship golf course.

One must travel elsewhere, to Warm Springs, Virginia, for instance, to find springs open to the public. There the springs are run in a way not dissimilar to practices of a century ago. Rubber and elastic bathing suits are forbidden (the minerals in the water destroy them), and male and female customers are strictly separated. Men sit in the nude on their side, water to their necks, holding onto ropes lest the tublike sensations put them to sleep and they drown. Women, dressed in Mother Hubbard romper suits, sit clinging to ropes in a nearby pool.

I am told that some mountain thermal springs are still unspoiled and undeveloped; I would love to believe that. Somewhere up there is a bubbling pool, just waiting for you or me, staggering out of the forest, tired and depressed, and it will slowly and miraculously soothe our troubles away. I haven't found it yet.

Shallotte Inlet, NC

For awhile I thought I had come across something similar–an undeveloped inlet of healing water on the coast of North Carolina, just north of the South Carolina border. Still relatively unknown! But when I went to investigate, I found that it too had reportedly been ruined. Not by moneyed interests who tried to make it excessively convenient and comfortable, like the thermal springs, but simply by pollution.

Even Joseph Hufham, who first popularized the healing qualities of Shallotte Inlet, has grown silent about the waters. He first learned of the curative powers about thirty years ago, he says, after he jumped into the water off his shrimp boat and was relieved of his blinding headache. He started speaking to others about the waters. In 1965, a woman who went to the waters with a cancer on her neck was healed. A couple from Rieglewood, North Carolina, were cured of five skin cancers in five days. Others reported that the water eliminated poison ivy, cleared up an infected arm, an infected ear, cut down eye inflammation. Hufham wrote all of this up in 1965 in a series of articles for the local weekly paper, the *Brunswick Beacon*. He sent articles to papers far away.

Hufham and a local physician, J.H. Dawson, investigated the source of the water's powers and finally thought they had identified it as a local patch of marsh grass. According to their theory, the four-to-five foot grass is filled with a substance of bread-like consistency. In its natural evolution, the reed grows, expands and finally bursts. Incoming tides wash the substance into the inlet, which is turned a milky color. Dr. Dawson has been quoted in the *Beacon* as saying that he hoped the water's "magical ingredient" might be something like penicillin and that it was certainly an "enemy to infection."

Hufham helped spread this theory, but he points to another source of the healing qualities. The 47th Chapter of Ezekiel in the Bible, he explains, describes a body of water not unlike Shallotte Inlet, "and wherever the river goes every living creature which swarms will live."

Whatever the source of its powers, the water found a great many people eager to believe in it. They still come, a couple every month. They bring yellowed clippings from occult tabloids, and from gossip sheets, with articles on the waters. They come on the basis of rumors. They come in station wagons filled with plastic gallon jugs for carrying the water back. They leave on the bus, sending along containers of water as their only luggage. They come with cancers and infections and muscle ailments. One man from New Brunswick, New Jersey, recently brought his son, who had lost the optic nerves in his right eye. The local people, who seem torn in their beliefs in the water, direct them to the inlet and to particular spots reported to have successfully healed others.

Coleman Moore, who owns the only motel in town, sees most of them, and puts them up for the night. He sadly shakes his head when he remembers the two visitors from New Jersey, but just shrugs at most of the health seekers. "I figure they come down here and spend a couple days in a warm climate, relaxing, spending time in warm salt water and it can't help but help, no matter what." A local pharmacist is more direct: "They come down here wanting to believe. They're halfway cured right there."

For awhile Hufham wrote to various medical groups and governmental agencies to verify the waters' curative powers. But a few years ago, Hufham watched a barge dump a large supply of gasoline into the inlet, and he became wary of using it for his eyes. He stopped writing about it, and talks about it now only hesitantly.

Hufham did not stop believing in the waters. Like thousands of others around the South who have seen their healing waters taken over by the rich or ruined by pollution, he stands firm on a few points. "God has presented us with medicinal waters," he announces. "I wouldn't be without them if I needed them." He says that he has found a spot where the gasoline hasn't spread, and that the healing waters of Shallotte Inlet–like scattered thermal springs and mineral springs of the region – remain effective. One has to search a little harder for them, that's all. □

drawing by Eric Fagerburg, age 9

Smells Like Money

by The Kingsport Study Group

"DON'T LET TENNESSEE STINK" reads the caption on the child's poster hanging in the office of Dr. Joseph Smiddy in Kingsport. Belching smokestacks tell the rest of the tale. Dr. Smiddy is the only lung specialist in Kingsport, and for several years he has tried to alert the people of the area to what he terms a "continuing, permanent epidemic of respiratory disease."

No visitor to Kingsport can miss the fact that the town smells. But industrial pollution is more than an aesthetic problem, more than a problem for plants and animals, birds and fish. In Kingsport, some people are concerned that the air they breathe and the water they drink may seriously affect their health.

Tennessee Eastman Company – the largest employer in Tennessee, and part of Eastman Kodak – dominates Kingsport. The town began as a port on the Holston River, an important transportation link for settlers heading west through the Cumberland Gap. In the early twentieth century, a small band of entrepreneurs decided that the Holston River site would be ideal for a manufacturing city. It had raw materials, good communications with the rest of the country, an adequate supply of water, and good country people to provide a compliant workforce. In 1920, Eastman arrived and transformed a wood alcohol plant into what is now a huge chemical complex. With it, the character of the town was transformed. Today, with a population of 33,000, Kingsport is the industrial center of a mainly rural and agricultural upper east Tennessee. Communications are still good, the workforce is still compliant – the major industries in the town have no union. But in the course of its development, the natural environment of the town and its surroundings have been damaged, and with it the health of its people.

Dr. Smiddy says that many people, on moving to Kingsport, develop bronchial problems, and loss of their full breathing capacity. Like Kingsport natives, new residents are likely to suffer continuing sinus problems and coughs. People in Kingsport got very excited last year by an outbreak of Legionnaires' Disease – there were sixty-six cases in Kingsport. But Dr. Smiddy expresses as much concern about the year-round epidemic of respiratory disease.

Perhaps the worst health problems exist for the 14,000 employees of Tennessee Eastman and the 2,000 of the Holston Army Ammunition Plant, run by Eastman for the federal government. In its Kingsport plant, Eastman manufactures fibers (acetate, modacrylic and polyester), plastics (cellulosics), dyes and industrial chemicals. Tennessee Eastman is a division of Kodak, the second largest chemical company in the US and among the largest in the world. Behind the familiar image of every kid's first Brownie camera lies another reality for workers.

A growing recognition of the dangers of such workplaces led Congress to pass the Occupational Safety and Health Act of 1970 and set up an agency, OSHA, to enforce its provisions. But according to TOSHA, the Tennessee office of this agency, no inspections have been conducted at Tennessee Eastman. Don Witt, head of the Tennessee office, said, "One of the reasons why we never inspect the big companies is because the companies have excellent programs themselves. We don't go in because we know we probably won't find any violations." A former OSHA employee told a different story, however: "They (OSHA) really try to skirt the problem and Tennessee Eastman is too big for TOSHA to handle."

Since OSHA began, it has been increasingly apparent that the dangers of the workplace extend beyond the plant to the community into whose air and water it discharges its wastes. In 1976, Congress passed the Toxic Substances Control Act, which theoretically enables the Environmental Protection Agency (EPA) to control harmful substances manufactured and used by large companies. It is a weaker version of a bill proposed in the Senate two years before and vigorously opposed by the biggest chemical companies – Eastman Kodak, Dow, DuPont and Union Carbide. The new bill is limited to substances known to be dangerous – it does not allow for control of potentially harmful or suspected substances currently being made.

These acts of Congress follow increased national and international discussion about environmental health hazards. The National Cancer Institute recently suggested that eighty to ninety percent of all cancer results from environmental pollution. Out of the thousands of chemicals manufactured each year, only a handful have been studied sufficiently to determine their toxicity; many more are suspect. And because it may take decades for birth defects, cancers, and other diseases to

photo by Helen Lewis

A moving pipe line carries unknown chemicals through the TEC complex.

become alarmingly apparent, concerned citizens must look for the early warning signs in places where population and industry are most dense. With its mix of paper, concrete and textile industries, plus Eastman Kodak's chemical division and munitions plant, Kingsport is a prime case study.

PAYING THE COSTS

In spite of increased awareness of environmental health hazards, there is little public concern expressed in Kingsport. Residents are understandably reluctant to criticize the industries which put bread on their tables. As the local newspaper comments, Kingsport "smells like money."

But there are hidden costs behind that smell. Workers and local residents have to pay their own doctor bills, and the neighboring rural counties, downwind and downstream, are also affected by the city's pollution. In the surrounding area the rate of babies born with abnormalities is more than twice the state average.

In the chemical industry world, Tennessee Eastman ranks high in the amount spent on new control devices, but little is known about the actual harmful effects of the materials used. And Eastman employees are not told the real (generic) names of the chemicals they handle. The wife of one worker told how, even after a week's holiday away from Kingsport and numerous baths and showers, her husband's skin still smelled of acid – but neither she nor he know what kind of acid. The 1970 Occupational Health and Safety Act might have given employees the "right to know," but it has not been interpreted in this way. Now a national campaign is being waged by public interest health groups to get this right recognized in OSHA regulations. Meanwhile, workers at Tennessee Eastman deal with "number 9123," or with chemicals under their trade names.

Tennessee Eastman also tries to avoid paying compensation to workers who think their ill health is attributable to workplace hazards. Dr. Smiddy has experience of several such cases. He tells of one occasion when he was treating a Tennessee Eastman worker who was "gasping for breath." He tried to get information from the company about the chemical the man was working with. "Sorry – trade secret," replied the Tennessee Eastman doctors. Although the company has a large staff of physicians and extensive laboratory facilities, they share very little with the local physicians who treat their employees. However, local doctors know that Tennessee Eastman keeps check on employees who work in high-risk areas, and in some sections they carry out sputum cytologies every six months – the worker may not know the name of the chemical he handles, but he and his doctor can be fairly sure it is dangerous if he is one of those who "spit in the can."

DON'T BREATHE THE AIR

"I've lived here five years and practiced medicine, and there's never been any information printed in the newspapers that anybody was harmed, but patients can tell you that 'my buddy who worked on the bench to my left is in Duke Hospital gasping for his breath, and my buddy who worked on the bench to my right is in the University of Virginia Hospital gasping for his breath.' But in addition to breathing problems and lung damage, a lot of other things have happened: blood disorders, and some people who've worked in the same division developed neurological disease. There was a group of people working together on a chemical product who developed a form of paralysis. But you never read about this in the paper. The only way you get it is through the grapevine. Some of the grapevine is probably inaccurate, but I have the feeling as a physician that I'm seeing the tip of an iceberg."

– Dr. Joseph Smiddy

"Disability is a dirty word" in Kingsport, says Dr. Smiddy. "Even to talk about disease, disability or pollution is considered a criticism of industry." Many local physicians regard Dr. Smiddy as an object of amusement for his strong protagonist role; they themselves do not seek to change the unchangeable. But an examination of the history of Kingsport reveals how local industry has defined what is unchangeable. The transformation from sleepy river port to industrial complex was planned carefully from the top. With the aid and advice of outside industrial planners and the Rockefeller Foundation, the town fathers imposed the city manager form of government on Kingsport in 1917. An efficient governing force from the point of view of industry, it takes the important local offices out of the hands of voters. In recent history, workers in Kingsport have been paid more than the average wage for workers in the surrounding rural counties; the price they are expected to pay is silence.

Not all residents accept the promoted silence. Especially in those aspects of the industries which affect the community, there have been protests. Air pollution particularly has caused a flurry of interest and criticism in the last couple of years. The Kingsport *Times-News* carried a front-page report on February 5, 1978, of a survey among residents of the Kingsport area. Thirty-nine percent of city residents placed air pollution at the top of their list of "most severe problems." The figure rose to forty-six percent among those city residents who are also members of civic clubs, and fifty percent among residents outside the city. No other problem came near the agreement about dirty air.

West Kingsport has long received the bulk of the fall-out of dirt, dust and industrial wastes in the air. During 1976 and 1977, fifty-three residents signed a petition to get a study of the air pollution of Kingsport industries, and twenty-three of them blamed the bad air for their own health problems — asthma, bronchitis, allergies, lung troubles, chest pains. Others cited physical discomfort, itching and rash. After pressuring the Air Pollution Control Division of the state of Tennessee for a year, the residents met with its director, Harold Hodges.

They told him that the fall-out was always worse at night; they suspected that the incineration of wastes was increased by the companies when it was less visible. Because residents could see the silos at the Penn-Dixie concrete works "bubbling over" with dust, they suggested it was cement dust in the air. The Division of Air Pollution Control made a year-long study of the problem, at the end of which a spokesman said they were "developing a body of circumstantial evidence that would suggest cement and masonry products are the primary problems in Kingsport."

While residents were pleased that at long last the inspectors had made a study of the problems they had been living with for years, many also felt that it was too little and too late. The study dealt only with particulates, and only with six firms in the city. Tennessee Eastman was notably absent from the study, as are the substances in the air which have the greatest long-term health effects. In the words of a local pediatrician, William Griffin, "The problem here is what we smell, what we can't see, and what we don't monitor and don't know what it is."

An interviewed spokesman for the Air Pollution Control Division admitted the need for an in-depth study of Tennessee Eastman's emissions of organic chemicals into the air. He said that no studies have been conducted on gaseous emissions, and that much more sophisticated equipment would be needed in Kingsport to study such problems. "Tennessee Eastman is burning off chemicals and getting all kinds of exotic combinations; no one knows what effect they will have. Rarely do they get complete combustion from incinerators, and they are burning off chemicals we don't know anything about."

In response to federal and state environmental controls on their waste disposal into the Holston River, Tennessee Eastman says that their "incineration operations have become more complex in recent years, as the program to protect water quality has necessitated the incineration of solid wastes." In reply, Dr. Griffin says, "I'm breathing what the fishes used to breathe, and not only am I breathing what they used to breathe but (in) burning the stuff, they're making all kinds of mixtures; they don't even know what they're creating in the air. I think we have to be defensive about our health. It's foolish to ignore. If your lungs tell you there's something there and you start coughing and hacking and your sinuses get congested, your body is trying to tell you there's a problem — you know there's a problem."

DON'T DRINK THE WATER

Through wind and water, the legacy of Kingsport spreads across the surrounding areas. About 350,000 people live in the Holston River Basin; even miles from Kingsport, they still bear some of the costs of that industrial complex. Day in, day out, Tennessee Eastman releases 350 million gallons of waste water into the Holston River, sixty-five percent of the total daily discharges of all industries into the river. At times of low flow, in the summer months, all of the Holston River has to be diverted into the Eastman plant. Don Owens, biologist with the state of Tennessee Water Quality Control Division, says of Eastman, "It is too big an industry for the size of the river." The only way Eastman can get enough water from the river for its needs is through the cooperation of the Tennessee Valley Authority. TVA has agreed with Eastman to release extra water from its upstream Fort Patrick Henry Dam to meet Eastman's requirements of a minimum of 750 cubic feet per second.

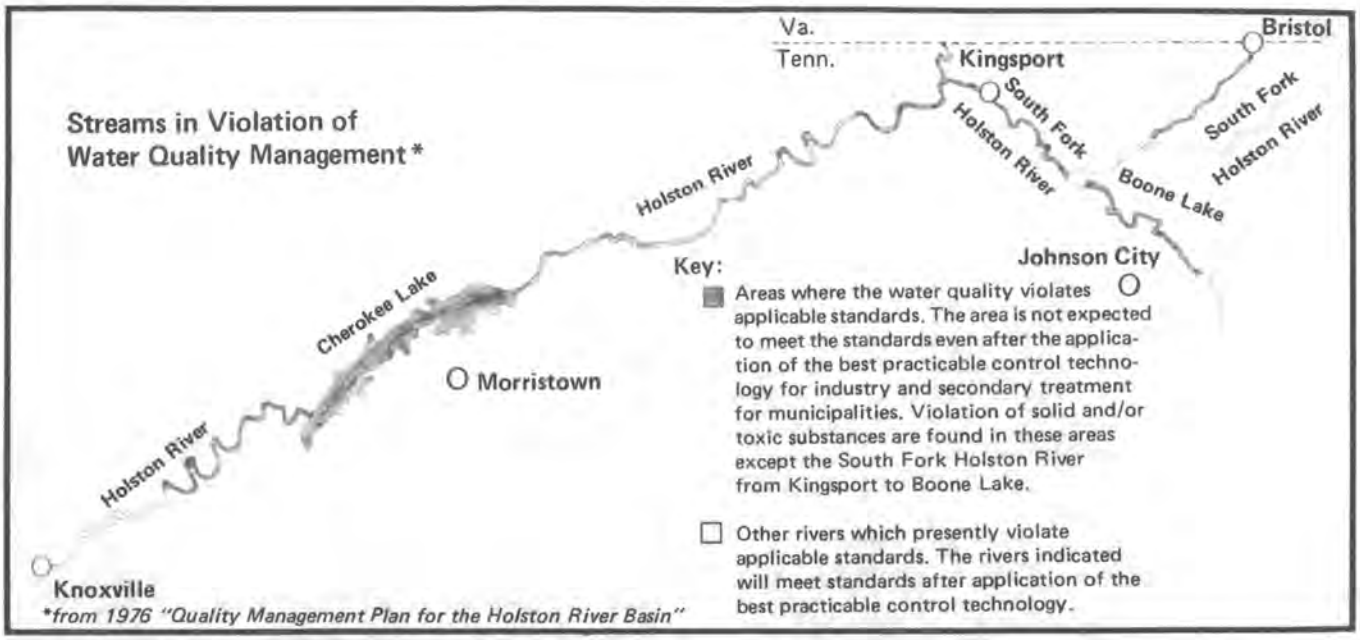
A classic example of what happens when a polluting industry cleans up just the minimum required by regulatory agencies, and no more, is seen today in Kingsport's plague — black flies. To an outsider, the clouds of tiny insects in the city and surrounding Sullivan County, and in neighboring Hawkins County, may not seem a problem for concern. To the people of these areas, however, they are a scourge, making life outdoors miserable from April through the summer. An army environmentalist team told the local newspaper that Kingsport had the worst black fly problem they had seen. Dr. Ed Snoddy, an authority on the black fly, now works with TVA's Water Quality Branch, and says that black flies are "pollution followers — to a point." In days past, when the Holston River was so heavily polluted that nothing could live in it for miles downstream from Kingsport, there was no habitat for black flies either. Now the water quality has improved slightly, "into a regime within the life zone frame of this species of black fly," says Dr. Snoddy, but not to the point where "normal predators and natural control mechanisms" might prevail.

As a result, the insects thrive. They swarm around animals and humans, attracted by the carbon dioxide in breath. Their bite leaves a large, angry welt, and some people are even more sensitive to them. One hundred cases of bad reactions (severe itching, swelling, pain) to these bites were reported in Kingsport in 1976. The females are blood suckers and carry disease among wildlife and animals. Dr. Snoddy says that there is little evidence that they transmit disease to humans, "but there may be some things we don't know about . . . . there are many obscure viruses which may be associated with them."

Treatment of the black fly problem is by yet another chemical, ABATE, which has itself caused some controversy. EPA has registered its use as safe only in the concentrations used for

photo by Parthy Morragan

Tennessee Eastman



midges and mosquitos, not the greater concentrations necessary for black fly control. A special exemption allows its use in Kingsport. It is ironic that a problem caused at least in part by chemical pollution should have to be treated with more chemicals whose long-term effects on human health are also unknown. Again, the costs of pollution are met by the community. Spraying the chemical onto the water helps control the black fly problem; its cure can come only with the return of the river to a healthy balance.

If Dr. Griffin thought that the fishes in Kingsport's water are getting a good deal compared to the humans in its air, water quality specialists would disagree. The river flows on, many miles downstream of Kingsport, through rich farmland and rural populations, carrying the wastes from the city of Kingsport down to TVA's Cherokee Lake and Morristown, and perhaps beyond, through the city of Knoxville into the Tennessee River, 140 miles downstream of Kingsport. According to the state Water Quality Control Division, "the most extensive degradation of water quality in the (Holston) basin exists in the Kingsport area." It identified the major polluters as Tennessee Eastman and its Holston Army Ammunition Plant, and the Mead Paper Mill. State biologist Don Owens says, "Eastman is probably the most difficult chemical problem in the state right now." Downstream of these discharges, as far as Knoxville, the state says, "water quality presently violates applicable standards. It is not expected to meet the standards even after the application of best practicable control technology for industry and secondary treatment for municipalities."

Several agencies – EPA, the state, TVA – monitor and report on water conditions in the Holston River and Cherokee Lake on an occasional or regular basis. Yet to the concerned layperson, study of such reports indicates one factor of overriding importance: we know very little about the extent of the damage being done. True, samples are taken; true, they are analyzed. But the standard water quality tests are for characteristics of the water like oxygen level and temperature, factors more important to fish than to human health. The organic chemicals and metals which are discharged into the river by the chemical companies upstream are seldom monitored. Yet it is just these substances which are currently causing scientists more concern for their possible effects on human health.

To analyze even a single sample of water for these substances is a very expensive process – it may take thousands of dollars for a single sample, especially if the combinations of chemicals involved are as complex and little known as those dealt with at Tennessee Eastman. In a recently published analysis, EPA found at least two chemicals that are known to be toxic. Others in the sample are known to be health hazards in the workplace, but their effects in drinking water are generally unresearched. The box "Chemicals in the Water" lists a few of the chemicals found.

In addition to the organic chemicals, there are metals in the discharges that also may affect human health. Tennessee Eastman's discharge of manganese at 9,500 pounds a day is well above the recommended limit for public health. Copper, lead, zinc and chromium are also known to have deleterious effects on human and animal health in some circumstances; these, too, are found in the Holston River below Kingsport.

But the biggest publicly recognized health problem in the Holston River right now is mercury, and its source is even more difficult to regulate than Tennessee Eastman. The Olin Matthieson chloralkali plant at Saltville, Virginia, used mercury for many years. When it closed in 1972, unable to meet environmental regulations, it left its legacy in the muck ponds of the old industrial site. From them the heavy metal seeps out, day by day, into the North Fork of the Holston River. It drops into the sediments of the riverbed, there to be converted by bacterial action into a highly volatile and toxic form, methylated mercury. It is released into the water and the air, but more importantly, is easily absorbed by fish. A community in Japan was poisoned by eating shellfish contaminated with mercury, and gave its name to the resulting disease, Minimata Disease. This is a severe disorder of the nervous system which can be fatal. There have been no recorded cases of Minimata Disease among the popula-

tions which have been eating fish from the North Fork of the Holston River as long as the plant has been in existence. But TVA's own expert on mercury suggested that its symptoms are like those of other neurological disorders, and doubted whether any cases that might have occurred would have been diagnosed as such by local physicians. The Virginia Public Health Department became so concerned by reports of fish with mercury levels above FDA limits that it closed the North Fork to fishing, subsequently allowing fishing for sport only. But who can police the miles of riverbank to ensure that no fisherman, catching an apparently healthy fish, takes it home to eat?

The mercury pollution extends well beyond the neighborhood of Saltville. Mercury in the sediments of the river apparently passes downstream, beyond Kingsport, to Cherokee Lake where the metal is found in some fish at levels above FDA limits. But the state of Tennessee has not yet decided to ban fishing in the lake.

Obviously, water can carry substances a long way. When the Olin plant was operating, its massive discharges of calcium carbonate made the water "hard" as far downstream as Lenoir City, 275 miles away.

"Cherokee Lake is dying," says Pat Card, who, with her husband, runs a boat dock on the lake, and, like other operators, depends on the lake and the fish for her livelihood. The boat dock operators present a grim picture of fish kills, stunted growth among game species, and fish with open sores. Dewey Smith has been on the lake five years, and thinks that 1977 was the worst for pollution. His boat dock operation lost $15,000 to $18,000 in income last year. "No one wants to put a $7,000 boat in water that looks like coffee grounds." Pat Card says also that people around the lake who suffer scratches often develop infections. She wants to know what chemicals are going into the lake, and what effects they have, but no one will – or can – tell her.

What can people do when faced with these kinds of threats to their livelihoods? There have been hearings and meetings about the state of the river and lake, but they do not offer much help to ordinary people who, when faced with the "experts," are often silent. Dewey Smith went to one hearing on the state's water quality plan, but "I didn't say a word during the meeting . . . Eastman had fifteen lawyers; what's a man with a high school education going to say to a bunch of college professors?"

Tennessee takes the view that the waters of the state are the property of the state, held in public trust for its people. In 1975, the state Water Quality Control Division made an extensive survey of the whole Holston River basin, listing all discharges into the river from industries, municipalities and other sources, and making proposals for the control of pollution from these sources. The report stated that "the people of Tennessee, as beneficiaries of the [public] trust, have a right to unpolluted waters." Tennessee Eastman objected to the water quality control plans, however, and sued the state in November, 1975.

This suit was dismissed after the state agreed to some concessions. As Tennessee Environmental Council's Jonathan Gibson said of the weakened standards in the new plan, "The people lost." Gibson spoke at public hearings on the revised water quality control plan, held in Morristown in November, 1976. "It does not take an attorney to be appalled at the way the Tennessee Eastman Company has used legal, political and economic threats to escape full and equitable compliance to the water quality laws of our state."

Constant daily pollution of the waters of the Holston River by industrial users, past and present, is one

CHEMICALS IN THE WATER

Among the chemicals found in appreciable amounts in one EPA sample of the water of the Holston River below Kingsport were the following:

Name	Known Workplace Hazards
Trichlorobenzene	All the chlorobenzene group irritate skin and eyes; direct contact may lead to dermatitis. High-level exposure may have an anaesthetic effect and may also cause liver and kidney damage. Known to be toxic to fish (EPA report).
Trichloroaniline	All the chloroaniline group irritate the eyes. There is a strong association with the disease in which the level of oxygen in the blood is diminished: methemoglobemia. Known to be toxic to fish (EPA report).
Diphenyl Ether	Extremely irritating to eyes and air tubes. High doses may cause irreversible kidney and liver damage. Repeated or prolonged exposure may cause skin irritation.
Copper	Experts do not agree. Known to be toxic when given to animals.
Manganese	Highly dangerous to workers in mines and in the manufacture of permanganate. Manganism is a crippling disease of the nervous system akin to Parkinson's Disease.
Chromium	Strongly associated with lung cancer among its workers: rate is 29 times that of the general population.
Lead	Well known lead poisoning effects for both workers and those exposed to lead in their environment, through paints, pipes, gasoline fumes, are anemia, kidney disorders, brain damage.
Zinc	Increasing concern about the health and fertility of workers in the zinc industries.

form of environmental health hazard. Another, sometimes more dramatically visible to people in the river basin, lies in the "spills," accidental or otherwise, from those same industries. Says biologist Don Owens, "It used to be that they would dump everything into the river without telling anyone . . . . Eastman has got a lot better at reporting spills." Today, the list of chemicals reported by Eastman to have been spilled into the Holston River is alarming enough; there is no speculating on the proportion of unreported spills. The box, "Chemicals Spilt by Tennessee Eastman," shows just a few from the long list reported by the company in recent years.

"Eastman's chemicals foul Morristown's water supplies"; "Morristown hauls water for drinking"; "It should not happen again!" – so was the dramatic news broken to Holston Valley people of a spill from Tennessee Eastman that could not be ignored. On February 4, 1977, Eastman employees washed approximately 7,000 gallons of ethyl pivalate into the storm drains leading to the Holston River. A report to EPA stated that the chemical was nontoxic, and that it would be dispersed by the time it reached Morristown, the first intake for drinking water downstream of Kingsport. The weather was against Tennessee Eastman, however; the river was very low and very cold. The chemical stayed in a mass, and a week later, citizens in Morristown began besieging their utility commission with reports of a foul taste and smell in the water coming out of their taps. Reports compared the smell with walnuts, cherries, sewage and rotten eggs.

Morristown's residents must have empathized with Samuel Taylor Coleridge's Ancient Mariner – "Water, water everywhere, and not a drop to drink." Drinking water was supplied to the 75,000 people deprived of clean water through two tankers parked at shopping centers. Water was brought to the elderly and infirm in their homes. Beauty salon operators had to rinse their clients' hair in vinegar to get rid of the grease left by the water. Plants died when watered with it; pets refused to look at it; the FDA ordered a Royal Cola bottling plant to cease operations. But everyone's main question was, "Is it toxic?" The answers they received were various; they are set out in the margin.

At least one local doctor was sure that the chemical was having ill effects on his patients. At a public meeting, Dr. Donald Thompson said that he had "several patients exhibiting an allergic reaction to the chemical and has had several reports of children suffering from severe diarrhea." Tennessee Eastman's officials claimed the chemical was nontoxic, but under questioning it became apparent that they really knew very little about the effects of ethyl pivalate on people.

A Few of the Spills into the Holston River reported by Tennessee Eastman Company

NAME	DATE	AMOUNT	KNOWN HEALTH HAZARDS*
Aniline Sulfate	August 4, 1974	4,000 pounds	Known carcinogen
Toluene	January 16, 1975	19,480 pounds (from the Holston Army Ammunition Plant)	Known carcinogen
Acetic Acid	January 22, 1969 August 29, 1976 January 22, 1977	20,000 – 27,000 pounds 30,000 pounds 18,400 pounds	In raw form has a severe caustic effect. Is very soluble, and so easily penetrates human tissue. Chronic exposure in the workplace can cause severe bronchitis.
Diphenyl Ether	June 12, 1975 July 18, 1975	1,000 – 1,500 gallons Undetermined amount	In the workplace it is extremely irritating to eyes and air tubes. High doses may cause irreversible kidney and liver damage.
Propionic Acid	October 7, 1976	10,000 – 12,000 pounds	Moderately caustic effect.
Sulfuric Acid	August 4, 1974 September 15, 1973	9,000 pounds 4,000 pounds	When concentrated it is quite volatile and gives off sulfur trioxide gas and sulfuric acid mist, both strongly irritating to the respiratory tract. In solution it is corrosive to the skin and teeth.

* *Work is Dangerous to Your Health*, by Jeanne M. Stellman, PhD, and Susan M. Daum, MD (New York: Vintage Books), 1973.

Drawing by Janet Beyer

photo by Helen Lewis

"Tennessee Eastman declined to participate in our investigation. They said they were too busy preparing the list of chemicals they manufacture and use which the EPA requires under the new Toxic Substance Control Act."

Local feelings ran high. A $37.5 million class action law suit was taken out against the utility commission and Tennessee Eastman by two local businessmen. The chairman of the utility commission said that the Holston River "was created by God for His people and His creatures, and it must be cleaned up." As Dr. Thompson wrote to the local paper, "There's too great a risk from those chemicals which we can't see, feel, smell or taste — after all, we don't know what the long-term ingestion of such chemicals as those used by Eastman do to our bodies, but we can safely predict that it is not GOOD for us." The Morristown *Citizen-Tribune* voiced the fears of many of its readers when it asked in an editorial, "What if ethyl pivalate had been odorless and tasteless? Would we, the water customers, even have known anything about the spill? . . . What if it had been odorless, tasteless and toxic?"

In December, 1977, Morristown lost its "approved" water status. Michael Stanley of the state Water Quality Control Division said that Morristown's water supply is "the worst in the state," and "the water being pumped into their water filter plant compares with water going out a secondary treatment plant. It's unreal the kind of water they are pumping into their plant." Morristown residents recognise only too well the jobs-versus-environment arguments, but as Dr. Thompson wrote, "an industry that poisons the people and its own workers is certainly NOT needed by ANY community, lest Morristown ends as did Seveso, Italy."*

Tennessee Eastman declined to participate in our investigation. The company said they were too busy preparing the list of chemicals they manufacture and use which EPA requires under the new Toxic Substances Control Act. The puzzled layperson might well suppose that a company would already know what it manufactures. And whether or not this list will be publicly available in the next few years is uncertain. When asked about this, an EPA official replied, "You better get yourself a good environmental lawyer," and he cited the company's right to "trade secrets."

Tennessee Eastman's employees, lacking a union, have no place to turn when they are worried about the hazards of their workplace. Citizens' groups haven't the resources to analyze a company's products and emissions either. Employees do not know what chemical they are working with, and know it is dangerous only by the fact that they are tested, but they are not given the results of those tests. Doctors are not told what chemical makes a patient sick, so that he or she can be treated; the community is not told what is in the air it breathes and the water it drinks — "trade secrets" have been taken too far.

Why are we concerned about the chemicals Tennessee Eastman produces? A good part of the answer lies in an exchange reported in the American Public Health Association journal, *The Nation's Health.* At a meeting on toxic substances, a chemical company attorney was heard to wonder aloud, "Why do people ask one particular industry (chemical) to create a risk-free environment? No other industries are required to do that." The answer came back quickly: "Because those substances kill people, that's why." □

**Seveso is the town in Italy where the escape of a poisonous gas from the chemical plant caused both short-term and long-term health problems for residents.*

We are teachers and students in the Kingsport and Holston River area, who have an interest in health and environment and a concern for the people of the area. We continue our interest and our concern beyond this article, and invite the participation of others.

Kingsport Study Group
Appalachian Health Project
Box 358, Wise, Va. 24293

Beth Bingman, Jamie Cohen, Steve Conley, Maxine Kenny, Helen Lewis, Juliet Merrifield.

To Drink or Not to Drink

On February 4, 1977, an accidental spill of 7,000 gallons of ethyl pivalate from Tennessee Eastman, Kingsport, entered the water supply of the town of Morristown. Here is some of what residents read.

2/10, **Morristown Citizen-Tribune**: *Public health officials, local water department officials and Tennessee Eastman officials say the chemical in the water is non-toxic, and non-caustic and safe for Morristown water customers to drink. . . .*

2/11, **Chattanooga Times**: *The state water quality control division has ordered Morristown to stop using water from the Cherokee Reservoir because of a chemical concentration in the city's water system.*

Knoxville News-Sentinel: *There is a strong possibility that a slightly toxic chemical spilled into the Holston River at Kingsport will not get into the Knoxville water supply . . . . "According to the information I have, it (ethyl pivalate) hasn't been tested for cancer-causing effects," said Dr. Jim Selkirk, unit leader of chemical carcinogenesis and carcinogen metabolism at the (East Tennessee Cancer Research Center) . . . . "It could take months to get a definitive answer," he said.*

2/13, **Morristown Citizen-Tribune**: *"Boiling not advisable, EPA says on water" – Boiling does get rid of the smell and taste but it also concentrates the chemical into a more acidic form and it is not recommended, according to health department officials.*

2/16, **Morristown Citizen-Tribune**: *The levels of ethyl pivalate in Holston River and Cherokee Lake present no acute health problems, according to Fary Hutchinson, chief of the Water Supply Branch of the Atlanta Regional Office of the Environmental Protection Agency . . . Dr. Malcolm Harrington, a medical epidemiologist with the Center for Disease Control in Atlanta echoes Hutchinson's beliefs . . . A person would have to drink about 100 liters to have any toxic effects, he indicated . . . While discounting the toxic effects of the chemical, Harrington said it was probably advisable not to drink the water anyway.*

"...to their

by E. L. Ayers

In 1880, when Henry Grady and the other New South advocates began their campaign to attract Northern capital to their region, Kingsport was a muddy cow pasture. The town had once been a flourishing river port (thus its name: King's Port), but when a railroad bypassed the town in 1850, it began to die; the economic disorganization of the Civil War completed the process, and the town lay dormant for half a century. There was no Chamber of Congress prostrating itself before Northern capital in Kingsport, only vast mineral wealth and a strategic shipping location awaited the completion of the Carolina, Clinchfield and Ohio Railroad in 1909. The railroad's geologist reported to the New York banker in charge of the operation, John B. Dennis, that Kingsport was a likely site for manufacturing; all the materials necessary for the production of brick and cement, for a tannery, and for a pulp mill were gathered there. Dennis and his company bought the 7,000 acres that had been the old town of Kingsport and began to build a new one.[1]

Dennis was confident that the new town would prosper. Not only was there an abundance of lumber, coal, sand, limestone, silica and feldspar, but an untapped labor supply seemed waiting for an opportunity to man his machinery. The pliability of the mountain population was often stressed as the major advantage of the enterprise. One article, entitled "Kingsport, Tennessee, Where the Mountain People of the Cumberlands Are Being Taught the Advantages of Industry," opened with the observation that "they make exceedingly apt pupils." And well they should, thought the author, since Northern industry promised "a transformation from gloom to sunshine and happiness."[2]

Dennis, following a pattern of Northern investors before and after him, enlisted a Southerner to act as a liaison between New York and these mountain people. His choice was J. Fred Johnson, a small businessman from nearby southwest Virginia. Dennis and Johnson decided that their town should not fall victim to the problems that plagued many of the company towns that dotted the South: dependence upon one industry, ugliness, unplanned growth, and the resulting labor difficulties. The obvious answer was to diversify the industry that they brought to Kingsport, to plan the growth of the city before it could get out of their control. They began a highly successful campaign to attract several interrelated Northern industries to their fledgling enterprise and enlisted the aid of one of the most famous city planners in the nation, John Nolen of Cambridge, Massachusetts.

The cooperative efforts of Nolen and the industrial community led to rapid growth for Kingsport. The town swelled from less than one hundred inhabitants in 1909 to over 12,000 in the 1920s. Ten large factories, all subsidiaries of Northern firms, established operations there within the first decade.

The plan Nolen devised says much of the vision he and his clients shared. The major street terminated on either

---

E.L. Ayers is a graduate student in American Studies at Yale University; this essay is adapted from a larger study.

mutual advantage"

end with the two poles of the city's life: on one end was Kingsport's railroad depot and factories, and on the other, "Church Circle." Many of the city fathers, especially Johnson, were highly religious men and valued the religiousity of their employees. The limits of their vision, however, were demonstrated in another aspect of the city blueprint. Though the population of Kingsport was ninety-five percent white, Nolen's plan devoted special attention to the black population. He made sure that the playgrounds, schools and churches for blacks "were planned for in ways commensurate with the advanced standards set for the rest of the community." Kingsport's "colored section" was carefully set off from the rest of town by surrounding it with parks and by locating it on the lower ground near the railroad tracks.

The attitudes of the rulers of Kingsport toward workers were similar to those toward blacks: condescending yet benevolent, enlightened yet manipulative. Workers were granted rights, but only within limits drawn according to the ideals of efficiency and order. The city's leaders did not anticipate problems with labor unions; the mountain people were paid more than they had been accustomed to, homes were provided for them, and the industries were always more than happy to provide money for new uniforms for the workers' baseball team and annual picnics for their families. Since, as J. Fred Johnson told a Northern business magazine, "a workman in Kingsport on the local wage scale, which is considerably below that prevailing in the industrial districts of the North, is still able to live in extremely comfortable fashion," there existed the best of all possible worlds for the employer: "profitable manufacturing operations . . . without any oppression of labor."[3]

For the first eight decades of Kingsport's life, the city had no municipal government. J. Fred Johnson and the managers of the ten factories that formed the town's economy had instead charted an organization called the "Kingsport Improvement Corporation"; this group owned the water, electricity, sewer, and telephone services as well as nearly all real estate. All major decisions were made by the corporation in lieu of a government. After the city was incorporated in 1917, however, state law required that a municipal government be formed. Not surprisingly, the form chosen for this government was the city manager plan, the plan closest to that of the organization of a large business. Once again, advice was solicited from Northern professionals; this time the Rockefeller Foundation's Bureau of Municipal Research helped draft the plan.[4]

The Kingsport Improvement Corporation adopted the charter without a popular referendum of any kind, and saw its passage through the Tennessee state legislature. The city manager plan had the distinct advantage for the businessmen of removing "politics" from the administration of the city; the manager was appointed, not elected. In fact, there were no important elected officials, because the city manager in turn appointed the heads of the finance, legal, police, fire, health, and public works departments. And at least until the Second World War, every councilman elected was sponsored by the corporation. As testimony to the subsequent lack of interest in partisan politics, even after Kingsport grew to 15,000 residents, no candidate ever received more than 800 votes.

A reporter for *Nation's Business* was surprised by the ease with which Johnson and the industrial interests directed the town.

> 'How are you able to get away with that?' I asked bluntly.
>
> 'Simply because we have no partisan politics or professional politicians, because we want to manage our own affairs and the city is small enough that we can,' Johnson answered.

In 1928 an article in *Factory and Industrial Management*, entitled "Neighbors: How a Dozen Plants Work Together," quoted the manager of one of Kingsport's factories: "It is downright astonishing how many ideas can come up when a lot of men see each other frequently, and sincerely want to work together to their mutual advantage." □

Notes

[1] John Piquet, *Kingsport: The Planned Industrial City* (Kingsport, 1951); Ben Haden, *Kingsport, Tennessee: A Modern American City* (Kingsport, 1963); Howard Long, *Kingsport: A Romance of Industry* (Kingsport, 1927).

[2] *Manufacturer's Record*, 88 (December 10, 1925), p. 77.

[3] *Factory and Industrial Management*, 75 (May, 1928), p. 974.

[4] Harold Stone, et al, *City Manager Government in Nine Cities* (Chicago, 1940).

No Time Off
A Family Practitioner in South Texas

by Roy Appleton and Hilary Hylton

In the following profile of Dr. G. Arly Brown and the people he serves, the names of the patients have been changed to safeguard their privacy.

Roy Appleton is city editor of the Denton Record-Chronicle *in Denton, Texas. Hilary Hylton, formerly a staff writer for the* Corpus Christi Caller-Times, *is now freelancing in Austin. All photos by Peter A. Silva.*

"Some of this is pathetic, but you've got to laugh a little bit or you'll go buggy," says G. Arly Brown, MD, as the office door closes, ending another "session" with the Garcia family.

The Garcias are sick. Mentally ill. Living, as Brown says, in "total chaos." Mother, father and sixteen-year-old son are suffering from schizophrenia and an unusual blend of mental disorders that have caused "people who supposedly know what to do to throw up their hands."

Every month or so the Garcias of Duval County, Texas, climb into the family car, drive fifteen miles to Freer and visit with the doctor. They squeeze into the small office at the mental health clinic, where Mrs. Garcia politely takes charge. Her husband and son stare at the walls and mumble only when spoken to.

Mrs. Garcia tells Brown about life without Valium and sleep, life overrun with CB radios and police scanners. She talks about how the boy spends most of every night listening to all the lawmen and "good buddies" and watching the scanner's little red lights blink. She tells of sleepless nights filled with blinking lights, noise and the fear of inflated electric bills, how the boy sleeps until eleven a.m., and how she goes across the street to the restaurant and buys him breakfast "because he won't eat what I fix."

For Arly Brown, specialist in family medicine, these weekly get-togethers at the mental health clinic require only a few hours of time, but demand special efforts from a man who "makes no pretense about being a psychiatrist."

It's just part of the job. When you are *the* provider of medical care for

photo by Peter A. Silva

photo by Peter A. Silva

Dr. Arly Brown in the empty hospital.

much of two counties out back in south Texas, you see and hear plenty; and the call to action often comes with unusual twists.

In fifteen years of mending bodies in the heart of Duval County, Brown has seen poverty as widespread as the south Texas scrub brush, and knows how talk of hygiene and nutrition can wipe an expression off a patient's face. He has learned about leprosy, tuberculosis and the bureaucrats at HEW.

"I remember the federal government sending an inspector down here to look over the hospital. Well, when she got to the kitchen she just raised hell about our food service, and she told me to fire the dishwasher because she didn't have a high school diploma," Brown says with a seasoned snicker.

"Now here you had a woman supporting three kids on that little bit of money she was making, and here was some government inspector from who-knows-where who could care less about Freer, Texas, telling me to fire her. I told the woman no way.

"To show you how much that woman had on the ball . . . I asked her to send us material, written in both Spanish and English, about diet and preparing nutritious food in the home. And about two or three weeks later I got a package in the mail from Washington, and all that was in it was a booklet, yes sir, in English and Spanish, for preparing squid in its own ink."

"Something Had To Give"

At 44, Arly Brown is as much social worker as he is doctor. A majority of his patients suffer from diet and/or hygiene deficiencies. They lack health-related education and, as a consequence, an understanding of preventive medicine, and many live without the means to pay for even basic medical care.

Tuberculosis, diabetes and dysentery are more prevalent in Brown's patient area than in most regions of the country. He deals with a high instance of iron deficiency anemia, obesity, hypertension and other dietary complications. And, as in most rural areas where people spend a lot of time outdoors, the doctor treats numerous accident victims. Like others who deliver medical care in rural areas, where health professionals must do without medical centers, sophisticated equipment and the support of colleagues, Brown says, "You do the best with what you've got."

"When you come into the brush, it's like moving onto another planet. You just don't have the programs, facilities and services available. You don't have the resources and support you have in metropolitan areas," he explains.

Brown came to Freer in 1963 to set up a partnership with Dr. Lynn Tooke, a friend from medical school. A year earlier, Tooke had reintroduced the medical profession to the small town at the request of residents concerned about the loss of their two doctors.

Tooke spent a year trying to convince Brown they could both make a living in the area, and after twelve dissatisfying months in Beaumont, Texas, he gave in and came to Freer, a move Brown says he doesn't regret.

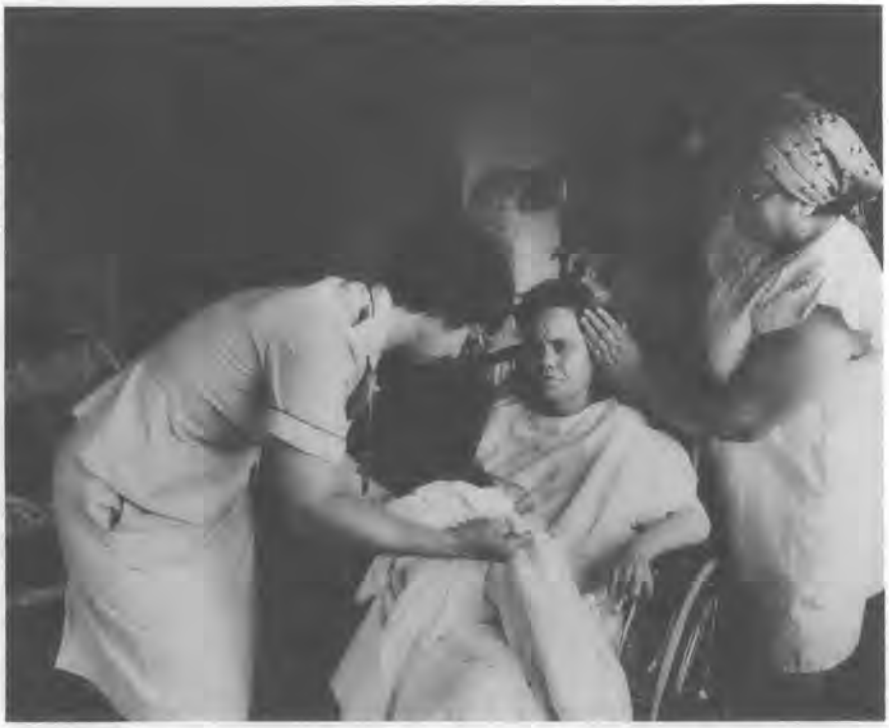
The two set up shop in the town's old wooden-frame hospital, stocked with such sophisticated equipment as a hot plate for sterilizing surgical instruments. Over the next four years, they bought new equipment and worked to upgrade medical care in Duval County, an effort that bore fruit in 1967 with the opening of a personally financed, thirty-two-bed hospital.

Three years later, however, Tooke and his wife died in a fire, and Brown was left with a two-person practice and the responsibilities of a busy hospital.

A hospital with such ancillary services as laboratory, pharmacy and x-ray is a golden nugget of medical care that many rural areas and most towns of 3,000 people don't have. In 1976 the people of Freer and the surrounding area learned again to do without when Brown, exhausted, was forced to close the hospital. Now, as before, area residents seek hospital and specialized medical care elsewhere, in places like Alice, thirty-five miles away, and Corpus Christi, eighty miles away.

"It was more than any man could handle. I went from Easter until November [1976] with only one day off, and not being able to leave, always having that responsibility hanging over my head, was getting me down physically and mentally. I was staying up two and three nights in a row, until

photo by Peter A. Silva



Home care in rural south Texas. A nurse makes a house call. The woman combing hair is paid to come by the house to make sure meals are prepared.

finally it became unbearable and something had to give," Brown recalled.

Now the sole provider of health care in two counties, Brown serves an average of 200 patients a week, confronting the problems peculiar to rural medicine and facing the unexpected sides of life as a small-town doctor. He is still looking for a partner and a way to reopen the hospital. On call twenty-four hours a day, seven days a week, he serves a predominantly Mexican-American population with a below-average standard of living. It is a situation not unusual for south Texas.

Consider the area surrounding Duval County, called the Magic Valley – a lush tourist haven where palm trees grow and restaurants and visitors from Dallas and Monterrey gather in exclusive shops on both sides of the border.

Here the Rio Grande River winds its way through silt-rich fields; trucks loaded with the Valley's harvest make their way north past the giant ranches and oil fields of south Texas. This southernmost region of Texas boasts beaches, palm trees, orange groves, cattle ranches and oil. And in the midst of it all, poverty and poor health are rooted and thriving like Johnson grass.

"The lush, semi-tropical beauty of the area often obscures its severe health, education and development problems," notes a study by the Lower Rio Grande Development Council. The area depends on agriculture. Unemployment is high and the population is 73 percent minority – Mexican-American. The Magic Valley is the core poverty area in the south Texas Triangle, that predominantly rural, often remote region stretching from Corpus Christi to Laredo to Brownsville. The Triangle boasts the lowest rural and metropolitan per capita incomes in the nation.

With economic, cultural and environmental factors stacked against them, the poor of south Texas are caught in a vicious cycle – being poor often means being sick and being sick means staying poor. Study after study points to the pressing needs of the people of the Magic Valley.

Yet near the Tropical Trail Highway, a family of nine lives in a two-room house – five of the seven children sleep in one room, the two oldest sleep outside in the old family car. Not far from that same highway is a migrant clinic where until recently a young doctor, Erik Svenkerud, practiced medicine. Dr. Svenkerud is now practicing in a remote region of Liberia, and expects to face the same challenges, indeed some of the same diseases he saw in south Texas. Svenkerud is not alone in his view of the region. Health researchers and professionals often compare health care problems in south Texas to those in developing nations.

Along a remote stretch of road in Rio Grande City, surrounded by cactus, sits a tar paper shack with four children out front, playing with the chickens. It is a familiar sight in the rural unincorporated villages called *colonias* that dot the valley. Approximately ninety-six percent of the residents are native Americans whose families have long-standing ties to this area. Many own their small, wooden homes. And according to a survey completed by the Lyndon B. Johnson School of Public Affairs over half of those homes do not receive treated water.

In a 1975 report, US Secretary of Labor, Ray Marshall, then a professor at the University of Texas, stressed the significance of these findings. "Health care includes diet, water quality, sanitation...it does very little good for medical care to eliminate intestinal parasites in children, for example, if the environmental causes of those parasites are not eliminated."

Solving this problem alone will take a major effort. Alejandro Moreno, director of Colonias del Valle, a grassroots organization aimed at giving the *colonias* a voice, estimates that "there probably are still 10,000 to 15,000 homes without water lines in the area." And in the Triangle's Starr County, where two-thirds of the population live below the poverty line, nearly half of the homes do not have flush toilets, according to 1970 Census figures.

Health care experts cite the living conditions of many south Texans as only one factor contributing to poor health. Poor diet, illiteracy, geographic isolation, inadequate prenatal care and a lack of health education also plague the rural population.

Dr. Paul Musgrave, a state health official, attributes the high incidence of typhus to the rodent population and unsanitary living conditions. Overcrowded housing is also a factor in the area's high rate of tuberculosis, a contagious disease.

Leprosy is endemic to the region, which has the third highest incidence of the disease in the United States.

This has state medical authorities on the defensive, according to one state health official in south Texas; "I wouldn't give you the figures on leprosy if I had to.... I hate to see you mention it because there's a lot of people who depend on the tourist trade down here." Yet in spite of that burgeoning tourist industry, fifty-eight percent of the resident population earns less than $5,000 a year. And in this area rich with agricultural bounty, the LBJ study found seventy-five percent of the *colonias* residents – approximately the same percentage employed in agricultural work – suffering from malnutrition.

In 1970, Dr. Harry S. Lipscomb of Baylor University, testified before the US Senate about conditions in Magic Valley's Hidalgo County: "I doubt that any group of physicians in the past thirty years has seen, in this country, as many malnourished children assembled in one place as we saw in Hidalgo County." Lipscomb reported that "high blood pressure, diabetes, urinary tract infections, anemia, tuberculosis, gallbladder and intestinal disorders, eye and skin diseases were frequent findings among adults.

"We saw rickets, a disorder thought to be nearly abolished in this country, and every form of vitamin deficiency known to us that could be identified by clinical examination was reported...."

In the eight years since Lipscomb's testimony, little has changed. A major problem is the scarcity of health professionals willing to work in south Texas. A 1973 study of health manpower in the state found that no county in the Triangle met the American Medical Association's suggested physician-population ratio of 1 to 566. In Starr County, for example, there is only one doctor for every 6,900 people.

A more recent manpower survey revealed that several counties have only one resident physician, other areas none at all. Five regions of the area qualify as "critical health manpower shortage areas" (physician to population ratio exceeding 1 to 4,000) and are served by federally employed National Health Service Corps doctors and nurses. Several counties in the Triangle have only one dentist, and in rural areas mental health clinics (where they exist) are pitifully understaffed.

With health manpower both inadequate and maldistributed, with clinics, hospitals and doctors' offices failing to plug the gaps in the health care "system" of south Texas, many unfortunate people fall between the cracks, like the bed-ridden elderly couple in McMullen County, the Zapata County child with rotting teeth, the ailing farmworker in Starr County.

"No Place for Orthopedic Surgery"

In the country around Freer, Brown has been the first and last hope for medical care – unlimited and unrestricted. He has spent five days and nights, "with time out only to shave," caring for a critically ill heart patient. He and his staff have treated the fourteen victims, many severely injured, of a two-car collision outside Freer.

He has seen the government close the blood bank in Freer; he has stood by helplessly as his hospital staff unpacked the one pint of "reserve" blood from Corpus Christi; and more than once he has watched Freer's volunteer ambulance drivers carry away bleeding patients he knew would die on the road. And throughout it all, Arly Brown is most frustrated "when you see an individual who has a significant problem and who needs a particular type of care that you just can't provide."

Sitting at his desk, beneath his diploma from the University of Texas medical school (issued "back when if you weren't studying to be a neuropathologist, something was considered wrong with you"), Brown isn't stingy with his thoughts on the practice of rural medicine.

"If you want to get rich as a doctor, a small, rural area is not the place to come to, because you're not going to do it. A considerable amount of your work is charity (Brown estimates his at thirty-five percent), and you don't have a charity hospital to send them to if they can't pay. That's just another problem in getting doctors to come to the country."

For Freer's country doctor there is no barter for medical care, though there are occasional gifts of venison, pickles and honey.

And although there is no place for orthopedic surgery, Brown's first love, there is always the call to special duty: the pregnant horses, the snake-bit dogs and humans and the injured deer.

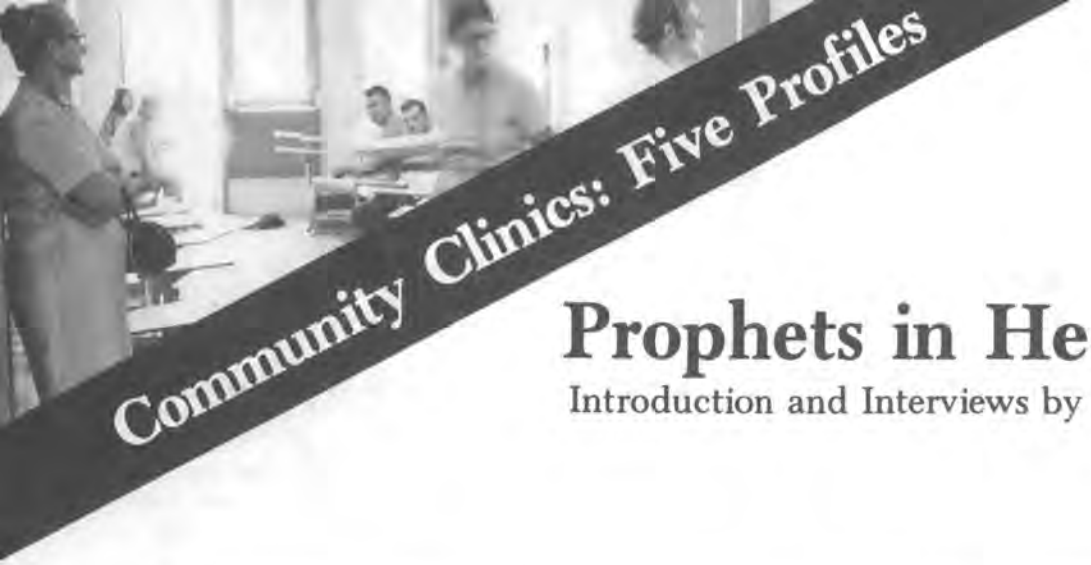
"I've been told I'm a crazy idiot for staying around here by any number of my colleagues. I get it all the time, and I just tell them I'm not smart enough to leave," he said, walking through the stillness of his hospital.

As for his colleagues, the doctor takes issue with those who "feel they cannot practice medicine short of being around a medical center.

"They have to stay right around the ivory tower and they feel it is the only place adequate medicine can be practiced. But I think they are badly disillusioned and making a bad assumption." □

photo by Peter A. Silva

A nurse midwife delivers a baby in a clinic in Raymondville, Texas.



Community Clinics: Five Profiles

Prophets in Health Care

Introduction and Interviews by Richard Couto

Rural Southerners don't cite statistics on illness and lack of health services, but their everyday experience makes them authorities on the problems brought on by the unequal distribution of wealth, increased specialization by physicians and the proliferation of technology in medical care. Their experience has made them aware that anti-poverty programs, scholarship programs, foundation and government initiatives, and health insurance mechanisms alone will not create the health system they want.

In some cases, however, these programs have encouraged groups in the South to initiate health efforts, especially the construction and operation of health clinics. Some were begun by medical schools, like Mound Bayou, Mississippi; others were supported early by War on Poverty funds, like the Lee County Cooperative Clinic in Marianna, Arkansas. Churches supported the establishment of the Cary Christian Health Center and the Voice of Calvary Cooperative Clinic, both in Mississippi. In some cases, already existing groups like the Federation of Southern Cooperatives of Epes, Alabama, and the South East Alabama Self-Help Association in Lowndes County, Alabama, initiated health programs. Other clinics began because of new community groups, organized with the specific purpose of establishing a clinic; the Mountain Peoples' Health Councils in east Tennessee are examples of these.

Community efforts at health care are inextricably linked to an American health care system; too often boards, administrators and providers must adjust to each other in a different political setting, one in which community people are invested with decision-making authority. Finally, finances – public and private – are more geared to what physicians charge than to what is needed to promote health. Inevitably, community health efforts must reconcile themselves with a health system which largely ignores rural and poor people. Consequently, community dreams of twenty-four hour service, emergency care and comprehensive programs including preventive medicine, nutrition, housing, water, testing, education and more, are frustrated by the limitations of the model of American health care, the private physician.

In a national health system that does not know cost containment and where the costs are determined by urban-based, profit-motivated providers, the people most neglected, with the greatest health needs and the fewest resources, are pressured to be the most cost-effective. The community people must deal with health care as a commodity, without a sense of community.

The experiences recounted in these links have presented obstacles to the creation and maintenance of meaningful health services. Invariably community groups require the assistance of health providers and meet initial opposition. Local doctors often view community action as unnecessary or as implicit criticism of their work.

Even when initial opposition gives way to cooperation – or indifference – community groups confront other obstacles. The geographic distribution of professionals adds to the problem of physician shortages. Community clinic profiles all fall within this context, and are related to other facets of health care discussed in this issue. Proposed national health insurance programs, for example – with the exception of the Dellums bill – skirt the central issues of control of medical education and the distribution and nature of services. The case of the UMWA Fund illustrates that even well-established progressive medical programs can revert to the physician-dominated fee-for-service model. Health Systems Agencies may forge another link in the medical-political alliance unless there is representation and effective participation by those who experience first-hand the present inequities in health care.

Efforts to provide care where there was none before and to charge according to the ability to pay were hailed as political models by health activists and overdue justice by the community people involved. In retrospect, these efforts illustrated that justice initiated from below is fragile, and that the economics of equity conflict with a health system motivated by profit. Community control of health resources is an ongoing struggle that is fostered not only by a vision of the future, but by an understanding of changes required in the present as well.

Prophets do not so much tell the future as they make plain the meaning of the events of their own time. In this sense, people who have worked at the community level to achieve health care for underserved communities have much more to tell us than merely the account of their efforts. Their work tells us about everyone's health system and what we must do to achieve a system of care that is accountable to people.

Richard Couto is director of the Center for Health Services at Vanderbilt University.

Fayette County, Tennessee

Sick for Justice

Square Mormon

The Rossville Health Center is in many ways a continuation of the civil rights movement in Fayette County, which Robert Hamburger eloquently documented in Our Portion of Hell. *The experience of board members with previous struggles and the close relationship of the board to local churches (three of the original board members are preachers) prepared the Poor People's Health Council for the political battle necessary to bring meaningful health care to Rossville. The resulting integration of the board's view of politics and theology is best evidenced by their unique perspective on the health center as analogous to Israel's source of deliverance from the bondage of Egypt, rather than simply as a small business or even an innovative community clinic. One man who exemplifies that perspective is Square Mormon, president of the Poor People's Health Council which runs the clinic.*

I serve as Chairman of the board, and we have thirteen members now on our board. The Council makes a policy and we look out for the welfare of the people. We're trying to construct a building and we're trying to get more trailers as our clinic grows larger. We set plans and policy like that. We also do more than just run the clinic.

Me and the people that started with me in 1960 in the civil rights movement before the clinic existed, we were working for poor people back then. In the beginning, when there was so much heat in Fayette County, the landlords were sort of confused by our people registering to vote. Lots of people had stayed on their land for numbers of years and some of the black people of Fayette County thought that the landlords were their best friends and if you told some of them that the landlords weren't their friends at that time, you'd have had a fight.

But when they attempted to register to vote in '60 – at that time the black population was about seventy-five percent of Fayette County – the white, they knew the population of Fayette County. They thought if the Negro got all registered up and raised up about justice and right – they thought the black folk would try to take over everything. This upset them very much because they could see things that the black wasn't thinking about. The black didn't want to run Fayette County; they wanted to be a part of Fayette County. They wanted to be of citizenship in Fayette County. They wanted to send their children to the best schools and whatever the system of the federal government was, they wanted to be equal in it. But I don't think the white understood this. They thought that the black would try to pay them back after the way they'd been treated down through the years from the slave owners and the plantations.

We could understand that they looked at it in another different way. They had it drawn out in another picture. Maybe some were so prejudiced they feeled that they shouldn't be on the level with the black man, but howsoever, we were determined to explain and to show them and to tell them what we wanted. We wanted to be heard, we wanted to be part of the federal government, and we wanted to make sure that our people were not the last to be hired and the first one fired.

That was a hard task, but the Negro was determined and we continued to register and continued to try to send our children to the best schools, and we continued to try for higher wages so that the Negro would be paid as the white was paid. We wanted to be paid by our qualifications. For a long time we went through a lot of suffering before we could demonstrate to the whites that these things were right. So we put the pressure on them through '59 up through the '60s up to '70.

So these are the things that we thought were wrong. The people in Fayette County, when their eyes came open, they really had got sick for justice and they were willing to pay any kind of price to be paid to be heard.

As we were working in the movement, we began to seek around, to find out what we could do for health care. So at that time, we had a little freedom school going that was very

successful. We were reading about Negro history and people back when they couldn't read or write, and how they fought for justice. So one day we were talking about considerations for health care, how we had no doctor.

"The first year we started a health fair we couldn't get a school from the board of education, and it was like it was when Jesus was born. We didn't have nowhere for the students to come to examine the people . . . . But we had faith because of the students."

No doctor in Macon, no doctor in Moscow, no doctor in LaGrange. We had a lady coordinator by the name of Virgie Hortenstein at the freedom school. We said to her, "How can we get a clinic together? Do you have any experience, do you know how we go about getting a clinic?" She helped arrange a meeting with Dr. [Les] Falk and Dr. [Ernie] Campbell of Meharry and they advised us at that time to keep on organizing ourselves and keep on getting together organizing ourselves, and they would go back to Nashville and they would be in touch with us.

They went back [to Medical College] and talked to the students about their interest in working with people who would like to have a clinic. And the students at that time were going different places and having health fairs and they thought that west Tennessee would be a good place where they could set up and get going. And it was because we had a dream of health care because we had seen so many of our people suffer and die for health protection. And so some of the students came down, and I talked with them and we asked them what could we do, because we insisted that they come down.

They said, "We would need some homes because there would be students coming out of school and they would need a place to stay." And I said, "That would be no problem. As bad as we need a clinic and as bad as we need our people to be examined we will do everything we can." We asked them, "How many homes would you need?" And they said, "We would need twenty-five or thirty homes." We went out and got forty homes. We had more homes than we had students.

At that time, we had a movement called the sheet movement. We went around to a lot of people and we got a lot of sheets from different ones, so that those who were keeping the students who didn't have enough sheets, we would give them two or three sheets for the students to sleep. We called it the movement, the sheet movement. We had sheets, I mean, even when we started the health fair, we had sheets to make partitions for the people to be examined.

The first year we started the health fair we couldn't get a school from the board of education, and it was just like it was when Jesus was born. We didn't have nowhere for the students to come to examine the people and bring all these good ideas and opportunity to bring health care. But we had faith because of the students.

Some of the people working on it were from the civil rights movement and worked with me, and many of the officials of Fayette County looked on us as old troublemakers. However, we went to them and sat down with the power structure and we explained about the health fair to them. Each person explained why we were interested in having a health fair. They kept listening to our story. I was about the last one to testify.

I said, "My concern in being here, as living in Fayette County – I was born and raised here – and I know the problems of our people, my people." At this time our doctor, Dr. West died. There were a lot of farmers in the field who lived away from him out in the ghettos and in the thickets, you might say. You know, these houses that sit out on the old dirt roads, the old plantations; and we were sometimes a mile from the gravel road. We had to come out a dirt road about a mile to come to the gravel road and then we'd go over the gravel road and, you know, we didn't have any hard tops until '57. We saw numbers of our own people die for lack of attention for health care. Even if you called a doctor, they'd have to come from twenty-five miles away. So I said, "I've seen so many of my peoples die without doctors since the death of Dr. West. We sit down in Rossville, twenty to twenty-five miles from Somerville and thirty-five miles from the Memphis hospital, and see babies die for attention and people get sick and die for attention."

I remember at that time a white man rented a place down here. He took sick one night and they called the ambulance from Somerville to come and get him. I told them, "Just like Mr. Campbell, a lot of you all know him, took sick the other night." And I said, "He got sick and they called for the ambulance and it was like an hour coming, and they put him in the ambulance and on the way back to Somerville the man died." And I said, "I think if we had a clinic with doctors it is possible that that man would be living. I think that that man died for lack of attention and I know numbers of babies died for not having doctors.

"We have had midwives who do their best, but when a woman has problems, we would call a doctor and sometimes it was too late. You know with 23,000 people in Fayette County, I feel like the clinic should be like churches. The churches are where the people are at. You should bring the church and the clinics to where the people are. I think that people are very interested in putting this together and I think it is possible and this is my concern today."

We sort of convinced the power structure that night. I remember the meeting; I was very surprised. Dr. McKnight said, "I have to say, there is a need for a clinic and for more health care, so I will say that I am in favor." Then I think Sister Guthrie asked him, "Would you make a motion?" He said, "Yes, I will make a motion that I am in favor." Then it was approved by the Quarterly Court and the Board of Education that we could have a health fair.

We only got approval at the time to have a health fair. The clinic was kept back because it was decided that we wouldn't come out with all of it at one time; we would just say health fair. And at the same time, while we

were having the health fair, our dream was to organize ourselves, get us a charter, then we would go back a little more efficient and then set up a clinic.

There were difficult problems when the power structure found out that we were trying to buy land to set up a health center. They never understood a brand new organization setting up on their own. Some of them said to me, "Now I can understand if the state was setting up a clinic, but I don't understand you setting up and trying to support a clinic on your own." It was a very strange thing to them because they had never seen anything like that happen, and I said, "Well, I feel like the state should have already had the clinic set up here because the state knows the people don't have health care in Rossville and the people knows it and the power structure know it, but the Bible says, 'The Lord helps those that helps themselves.'"

And as I remember, one time in the civil rights movement when I was going around raising people into getting schools integrated, some of the power structure told me, "Square, can't you find something else to do to help your people besides making trouble?"

So I laughed and I said, "I hope I'm not making trouble." I said, "I don't look at having black children going into schools that were called white schools like you look at it. I look at it as if it's not white schools. It's not black schools – it's government schools and all the taxpayers have the same right to go to that school. They have the right to the best of schools. I would like to see my child have the same books and the same opportunities and deal with inside restrooms just like anybody else. And we're all human. We're all human and I don't think we ought to be divided like this. We should be treated human and equal under law."

So he says to me, "I know what you're saying and that sounds well, but I just thought there might be something else you might be doing."

When we thought about health care, I thought we wouldn't have the same old difficult problems because we weren't registering people and we weren't trying to integrate schools. But when we went to try to do something for ourselves, we caught as much hell in just trying to set up a clinic and trying to raise money.

We felt like charity should start at home and spread abroad. The beginning money the Poor People's Health Council raised was a hundred out of their pocket and then we went to the churches, and the churches contributed money for a building. Then some of the people working at the health center, they had programs, we had picnics to raise money. The whole thing we were trying to do was to show the power structure, to show the federal government, and to show everyone that we wanted to do something for ourselves and hoping that they would join in with us.

I believe that you don't stand up and tell someone to do something for you, but you first do something for yourself. The people see that you mean something and that you struggle along with the difficulty and the problems that you're having and you don't stop at that and you're disencouraged and you pray about it, and you read and meet about it, and you ask God for knowledge and faith and more understanding and you work with all your cares and you have to ask God to give you courage to go where you said you weren't going to go and go further when you thought you couldn't go any further; that's the way you keep on moving.

That's the same thing in the civil rights movement when things got so bad. I would come home and I would wonder why things happen like this and if I could go any further, then I would think about what King said: "If you haven't seen anything worth dying for, then you're not fit for living anyhow. If Jesus had problems, he didn't have no sin, he didn't do no wrong; he was perfect and if he had a hard time, what about you." So I think about all those things, and I build up more encouragement to go back and continue and still fight. I felt down the road somewhere that if you keep working that reward was somewhere. So that way we kept going. We kept trying to buy land.

The planning stage of our clinic upset our doctors, some of the doctors got upset, after the board raised the money, after the church raised some money. We had people raise money and after some of the clubs had given us a hundred dollars and it looked like we were getting together, and TVA donated trailers. We put in a proposal for $30,000 to the state and this needed doctor approval. I got Mayor Farley to write a letter of support. And this helped so much. I went to a doctor and I got turned down. He said to me, "Square, I just don't understand. I would sign it but I really don't understand your organization. I'm not against you, but I don't know enough about it."

Well, I couldn't convince him to sign it. But we went on with the endorsements we got, and through the

Square Mormon and Bishop Dore: "We went to the churches, and the churches contributed money for a building."

help of the board, it passed.

We had to go to Brownsville one night, and we had to meet all the doctors from around; the union of doctors that make decisions about things. And we got two or three carloads of people. Dr. [Erica] Voss went with us, myself, Al Nelson, we carried along four or five board members, we carried some of the council members, some interested citizens. We got to Brownsville that night and Judge Rice, he's our judge, he found out, he told us they wouldn't let but two people into the meeting, me and Dr. Voss. He told me, he said what they were most concerned with was Dr. Voss' qualifications and that I should let her answer the questions they asked. That's okay, I can take care of myself. Dr. Voss, she can take care of herself. We were in there for an hour and a half. They asked Dr. Voss about her qualifications, her education. Dr. Voss convinced them she was qualified for her position and they agreed we should get the $30,000. That's just about some of the history of what we had to go through to get started with the clinic.

The clinic has made things better between blacks and whites in Fayette County. Some of the blacks, and a lot of the whites said it couldn't be done. We had convinced them it could be done. By setting up an integrated clinic, blacks and whites, a white nurse, a white receptionist, a black doctor, a black receptionist, we have shown that it could happen. It hasn't been easy. Some of our professionals walked off at times because our clinic was a black movement. It was an unfair thing to happen, but it happened. They fell out with the name of the place, the Poor People's Health Center. It had become a shocking name. They explained that the uneducated black was shocking to them, but it wasn't shocking when they came and the money flowed. They seemed to have forgot about health care. They began to look for fault. And they began to look to set up a clinic like they would like to see one come, destroy our ideals, our goals and to disencourage the black nation like throughout history, that this was impossible for black people to do.

The clinic has also made things better between black people and the power structure. At this time we have seven board members of some of the old civil rights movement leaders. Now at this point we have whites on the board: a representative from the Welfare Department, a representative from the Tax Assessors Office, from the Board of Education, the Mayor of Rossville, and others. Now when we have a board meeting we're able to sit down and talk, and we ask them for input and they're willing to give us input.

We don't have static from our local people at this time, and it seems like everybody wants to see a permanent building here. We also have whites come into our clinic, young and old, poor and middle class, and upper class. So we also have black and white working in the clinic. We also have a minibus that takes black and white to the clinic and to Memphis. So it has brought a better spirit, a better relationship. If we can work with all our friends and foundations, the federal government and the state, and we can convince them that we need a building and a facility that we can call home, then we will serve the unborn generation and the peoples from everywhere. Then people from everywhere can say, "This is ours."

I wanted to see a clinic built that our young people could be trained and be lifted by their bootstraps and would be able to come into health care training, nurses. I wanted to see something where students from Vanderbilt and Meharry could come out and have a place to go that they would have a chance to serve people black and white.

My whole goal was to see other organizations, another wing on the health center like maybe day care, social workers, and we could have something that would test water. So many people got sick and so many diseases that we felt like we could have something to check out all the wells, and we could have social workers go around and check people's houses for screens, check babies, see how they are treated, give advice to young mothers who might not know how to take care of children and to continually set up different day-care centers and maybe someday look after old folks, or even maybe have a bus that could move around different places and still give service. So this was some of our goals and our dreams in setting up a clinic, to see as we grow, to see what could be set up that could bring better health care and more enlightenment to our people. This is the movement's dream today. □

Mud Creek,

Like the Rossville Health Center, Kentucky's Mud Creek Citizens Health Project was preceded by a history of political struggle. In the mid-1960s, the residents of Mud Creek organized the East Kentucky Welfare Rights Organization (EKWRO) to address such issues as school lunches in Floyd County, strip mining, and miners' benefits, especially black lung. From the start, a very significant portion of their time was spent on health issues in Floyd County, and EKWRO achieved national attention in its attempt to reform the Floyd County Comprehensive Health Services Program. Despite its name, the OEO-funded health program provided no direct health services to people. Instead it served as a referral mechanism to local doctors, provided transportation for eligible clients and reimbursed local doctors for service to people unable to pay. When attempts failed to gain broader and more active representation of poor people on the board and a more comprehensive health program, EKWRO worked to cut off OEO support. Eventually in 1971, the Office of Health Affairs of OEO suspended funding for the program. It then worked out a compromise with local officials to create a new program, the Big Sandy Comprehensive Health Program which is still operating with support from HEW.

In 1973, several members of EKWRO, including Eula Hall, helped establish a clinic in 1973 on Tinker Fork under direct community control. The following interview makes clear that meeting the health needs on Mud

Kentucky

Sick for Clinics

Creek has been a continuing struggle. One constant problem has been the lack of available and willing physicians: without a doctor, the clinic cannot be reimbursed by federal programs for non-paying patients. There are other reasons for the difficulty in meeting the expenses at this and other community clinics. Fewer rural Southerners have health insurance available to them than any other group in the nation. Nearly half the people in the South who live on farms were without health insurance in 1968, and almost a third of those living in nonfarming, nonmetropolitan areas – like Mud Creek – were without it as compared to 36.8 percent and 24.2 percent nationally. Health insurance is most often provided as a fringe benefit to employees of large companies or workers with a union; consequently, where you find low-paying work and nonunion labor, you find less health insurance.

Medicaid is another problem: in 1970 only thirty-eight percent of the children in below-poverty families in Kentucky received Medicaid services at an average cost of $76, compared with the corresponding national figures of fifty-five percent and $126. Kentucky Medicaid pays only a portion of the charge for service and prohibits a provider from charging a Medicaid patient for the rest. Consequently, a community clinic loses money, under this arrangement, in treating a Medicaid patient.

Since the 1950s, the United Mine Workers Health Fund has been the predominant form of health insurance available to patients of the clinic, providing the facility with an average $5,000 each month. On July 1, 1977, the Fund abandoned this retainer system and instituted a fee-for-service system in which the Fund paid sixty percent of charges, and the patient, forty percent.

The following interview was conducted on July 28, 1977, when the Fund's policy change had already made its impact. But the clinic has continued to provide care for those who need it, whether or not they can pay, and has been near financial ruin as a result. The problem is compounded by the wildcat strikes which have left miners' families with no income to pay for health care. Despite a plethora of programs such as Medicaid and Medicare that are supposed to "cure" rural health ills, in reality the clinic's future rests with the commitment of the board and the staff, and their ability to "make do." This interview with Pat Little, administrator, and Eula Hall, social worker, at the Mud Creek Health project in Craynor, Kentucky, focuses on the dilemma they face if they are to keep their clinic open. In recognition of her commitment and achievement, Eula Hall received a Presidential Citation from the American Public Health Association in 1975.

Pat: Our clinic tries to give people what they need. We not only have a doctor and a nurse, but we also have a therapy room for black lung and a social worker that can look after people, to give food stamps, to go to hearings to see that their rights are protected and taken care of. A lot of these other programs around here look at us and wonder how we keep surviving. To a certain extent, they're not only surprised, but they're sorry that we do. We've been breaking even; I don't know how, but we have. But even with the pharmacy, we were only breaking even. We would see sixty and on up people a day. Our private paying patients, they pay what they can, you know, sometimes two or three dollars at a time.

Eula: About one-fourth of our private patients, which is about one-fourth of our patients, don't pay anything. It varies from month to month. Some months half of our private patients may not pay anything, it

Council of Southern Mountains

Eula Hall, left, and Roy Huffman at a 1972 outdoor meeting.

photos by Sally Maggard, CSM

Open house at the Mud Creek Respiratory Clinic, Floyd County.

depends on the status of the patient and their income.

Pat: Like right now [during the wildcat strikes], there ain't nobody working. Now that means because our doctor can't be reimbursed by the Fund and other people have no income, the clinic is providing a lot of free care. I wish you could see the stack that we have; we have just been continuing providing care – for June and July. A doctor comes in twice a week on Tuesday and Thursday, there are thirty or forty chart sheets for UMW patients every week, but we couldn't charge anything. They depend on the clinic and they need care. But we just can't keep operating like that.

Over the weekend I did our quarterly report and taxes, federal and Kentucky taxes and it nearly drove me crazy because I kept trying to figure out how can we stay open one more month. We're just barely making it. Then I told Eula, "Eula, we're just not going to be able to see the patients free-of-charge anymore. We're just going to have to close. We can't pay our staff."

You never know what you're going to get from Medicaid; you can't depend upon them at all. We billed them $5,000 for March and we got $1,900 back; you don't know what you're going to get. They have little letters to tell you why they switched the pay, that the patient was ineligible at the time or the name was wrong or the numbers were wrong. And you know you can't bill a state aid patient for the rest of what it costs you.

But where we have had bills for Medicaid of $1,300 to $1,400 a month, our bills for June were $480; now that's just two days a week, but that's it. Medicaid won't reimburse physician's assistants or nurse practitioners, they just reimburse the physician and we only have him two days a week since our regular doctor left.

Eula: We filled out a proposal for the Robert Wood Johnson foundation, but the doctors we had at that time didn't want it. They didn't want money from foundations or anything. We filled out everything but they wouldn't fill out their part. So it fell through. They said they didn't want to spend bureaucrats' money, but I'd just as soon spend bureaucrats' money as anybody's. We can provide good health care with that money. There ain't no better use for it.

Pat: We did have a grant from the government for black lung therapy. The grant was supposed to go until June, but they called in April and they said not to do it anymore because they ran out of money. The UMW Fund was billed for the respiratory patients that we were seeing separate from the retainer. The $5,000 from the Fund was just for office visits. The respiratory program is still needed, but we had to close it down. What really irks me is they set this up, you know, we had to borrow money to build that room on because we had to have a room for that before we could get the grant and then you have all this equipment and then, Kaboom! It's gone and we have to lay off our respiratory therapist, and all that equipment back there is doing nothing. I just can't understand some things the government does.

Eula: The University of Kentucky gave us a nurse and a community health educator one time. They gave us a social work student one time. I think they could help in a lot more ways. I think they could, instead of having all these interns all doing their thing down there at the University of Kentucky, they could put mobile units, or satellite clinics out here. I think they ought to go to where the people are; the people cannot go to them, not from here.

Pat: What we need out here is a physician who's dedicated. We've been trying since last year to recruit a physician. Our first two doctors were paid $12,000 a year. Our third doctor was a sister, and we paid her $8,000; she gave it to her order, and you know, she said it really didn't matter. We didn't have to pay her a big salary. But after those three we had a big problem finding a doctor we could afford. A pediatrician came and visited with us and she really liked it here, but she wouldn't come for less than $50,000 a year. So

that's the reason we went to the National Health Service Corps, because it would be difficult to pay out a big salary; but if things had continued with UMW we could have paid $30,000 or $35,000 for a doctor.

Our pharmacist is the highest paid professional; we paid him $15,000. That's a hard decision to make, but any decision you make, you make it for the patients. Now we'd never give anyone $15,000 if it were left up to us. If we get a doctor back, then we'll start looking for a pharmacist.

We applied to the National Health Service Corps directly but we got a letter back saying that we had been approved for a physician. I wrote and I called the day after and I told the guy that PA's wouldn't help us a bit because they weren't recognized [for reimbursement] in Kentucky. Well, the man that we had been working with called me back a little bit later and he was pretty upset, I guess, because I had talked to somebody else and he said we were still on the list for physicians but we'd have to wait, and there aren't any physicians available at this time, and besides, he said, "I don't think you'll ever get a physician because I've been out there and I've seen your place." So you see, I really don't think he's helping us. But this doctor who says she's coming, she's been out here and she said she really liked it. She's dedicated to her patients; she said that it was just what she was looking for.

I can remember when we first started. Have you ever been up to Tinker Fork? Well, it is kind of unbelievable. Using mayonnaise jars to hold tongue depressers and fruit jars for urine specimens. We had bake sales and rummage sales and things like that to raise $400 just to pay the rent. You know, if it hadn't been for the UMWA cutback, we would have made it. Or we could have borrowed it to go on, but the way things are, you're afraid to borrow to continue.

Eula: See, we're going to be forced to be closed; we're the only place that's providing free health care. We don't deny health care to nobody, regardless of their ability to pay; we see anybody who comes through that door, money or no money, and that's the intent of the clinic, to give health care to people that need adequate health care. But, how much longer are we going to be able to stay open without some funds?

Pat: We're paying our nurse and our receptionist and our lab technician full time, but they're only working two days a week, the two days when the doctor comes in. If I cut them down to just two days a week, they can draw more on unemployment. But we have to have them just for that doctor; it's going to kill us that way. It's just not going to work. I don't know what to do, I really don't. We have charts on 5,000 patients. Many of our patients are doing without health care right now. They're not going to other providers; they can't afford it. Doctors have quit taking new patients.

If we had half the money of some of these other programs, we could continue to provide service. Me and Eula, we borrowed $5,000 to start our pharmacy, and I felt much better when we paid that off, you better believe it. But that was the only way we could do it, you know, because we never had that much money to get ahead. We haven't been in the red, but we just barely make it month to month.

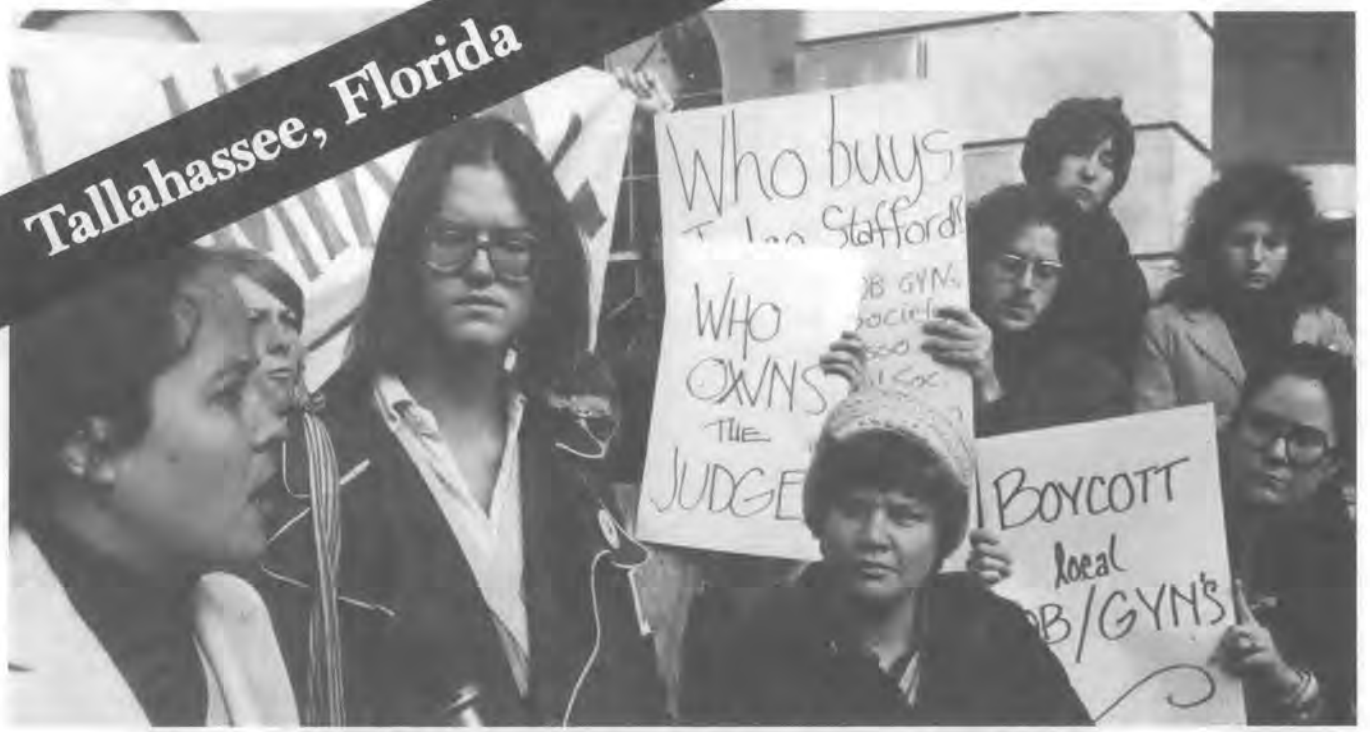
I think we're getting the job done. We had a call from the state licensing board last Thursday, about our state inspection. She said, "I have been to all the big hospitals, clinics, but I've never been anywhere where I felt the job was being done like it is here." It really made me feel good because just the week before the doctor said, "You all will never get licensed." I don't know why he said that. But I guess he had always worked in big hospitals. She said we were doing a better job than any other place that she had inspected. Yeah, that really makes me feel good. You know, that's the state talking.

But you know the staff, we have always worked together because you never get anything if you don't. It really gives you a good feeling, too, and like I told the state inspector, "I hope we'll be here when you come back."

Eula: I don't think I could be happy working anywhere else. I like to organize. I like to work with the UMW and the tenants' union and you can do a little bit of that and a little of other things, too. I really don't know what else I would do, I swear. Well, there are fourteen people out there right now that are waiting to see me about this and that and the other thing, you know. One needs a form for food stamps, anything they need in medicine or in anything else they need, they come to us. We're a comprehensive health program. You better believe it. □

Council of Southern Mountains

Welfare March, 1971: The residents of Mud Creek organized the East Kentucky Welfare Rights Organization to address a wide range of issues in Floyd County, including health care. Members of EKWRO helped establish the Mud Creek Clinic.



Self-Help Fights Back

by Linda Thalman
and Bob Broedel

In the 1970s, the health care choices available to women in Tallahassee, Florida, were more limited than an urban location suggests. Tallahassee Memorial remained the only hospital facility after the black-controlled Florida A & M University hospital was forced to close in 1971. Alternatives further diminished when the county health department's prenatal clinic closed after obstetricians struck over non-payment of charity cases. The medical community itself was ingrown and protective of its power (for example, the great-grandson of the founder of the Florida Medical Association is now the Executive Director of the Florida Board of Medical Examiners).

Meanwhile, in Los Angeles, California, the Feminist Women's Health Center was fighting to establish the rights of lay women to control their own health care. The Center's founder, Carol Downer, along with Colleen Wilson, was arrested in 1972 for "practicing medicine without a license." Charges against them for showing women how diaphragms are fit and using yogurt as a treatment for common yeast vaginal condition ended in acquittal, and the movement for women's Self-Help Clinics and abortion services continued across the country.

In Tallahassee, Linda Curtis and Lynn Heidelberg were as inspired by the Self-Help movement as they were incensed by the fact that local women were unable to get appointments with local doctors and were forced to travel up to 180 miles away for basic gynecological care. They traveled to Los Angeles to learn more about operating a Self-Help Clinic. In March, 1974, they opened the Tallahassee Feminist Women's Health Center (FWHC) offering pregnancy tests, basic health information, and outpatient abortion services.

Finding a doctor willing to work at the clinic was only one of many hurdles for the FWHC, but the clinic in its initial stages functioned relatively smoothly. In June, 1975, an article in the Tallahassee Democrat *credited the women's clinic with lower fees than other local doctors could offer. Within a month, two local physicians quit the FWHC, threatened with loss of status and privileges at the local hospital. Refusing to close its doors, despite a physicians' boycott, the FWHC filed a precedent-setting Federal antitrust suit in October, 1975, against six ob/gyn physicians at Tallahassee Memorial and the Executive Director of the Board of Medical Examiners, charging that they had conspired to monopolize women's health care in Tallahassee. The Florida AMA supported the physicians, while the American Public Health Association and several groups devoted to women's health care sided with the FWHC. One year later, twelve hours before the antitrust suit was set for trial, the judge threw the case out of court, ruling that the doctors had acted within the scope of their authority as a "self-regulating profession." The case is currently on appeal to the Fifth Circuit Court in New Orleans.*

The court case was only part of their battle to survive. At the same time, the FWHC sought a patient transfer agreement with Tallahassee Memorial. But this request for safe, efficient transfer of patients in the

---

Linda Thalman is a member of the Young Socialist Alliance; Bob Broedel, who helped with the interviews, is a member of the Science for the People *magazine editorial board. The Feminist Women's Health Centers are preparing a comprehensive book on women's health which will be published by Berkeley Books in December, 1978. For more information, write FWHC, 1017 Thomasville Rd., Tallahassee, Florida 32303.*

event of a medical emergency was continually denied by the Hospital Board.

Then in 1977, thirty women representing a national organization of women's health projects (W.A.T.C.H.) conducted a consumer inspection of the maternity ward and nursery at Tallahassee Memorial. Four were subsequently arrested and charged with criminal trespass. Although it later retracted the statement, the Tallahassee Democrat *claimed that all thirty had "barged into the nursery" and refused to leave. However, clinic representatives maintain that only four people entered the nursery and left when asked after less than a minute and the entire "inspection" lasted only fifteen minutes.*

The state Attorney General's office took the women to trial on a charge that did not allege a crime – that of entering a public building. As the women had clearly entered the building, the jury convicted the women, who later received unusually harsh sentences of $500 and thirty days, and $1,000 and sixty days. This case is also being appealed to the Florida Supreme Court.

The clinic, which began with a group of women sharing their experiences with health care in general and eventually committing themselves to giving better care, survives in Tallahassee. It serves an average of 100 women a week with a staff of fifteen full- and part-time workers. However, its struggle to provide services to women in an atmosphere that promotes growth among the participants and remains free of the attitudes the medical community has traditionally shown toward women, continues. In the following interviews, conducted in February, 1978, Linda Curtis, Marian Banzhaf, Risa Denenburg, and Susan Griffin discuss the structure of the clinic as well as its underlying concept of self-help with Linda Thalman.

Question: What kind of services does the Feminist Women's Health Center (FWHC) provide and who do you serve?

Risa: The FWHC serves women in Tallahassee and surrounding counties and from Georgia and Alabama, too. About forty percent of the women who receive services are black. Women of all ages and class backgrounds come to the clinic.

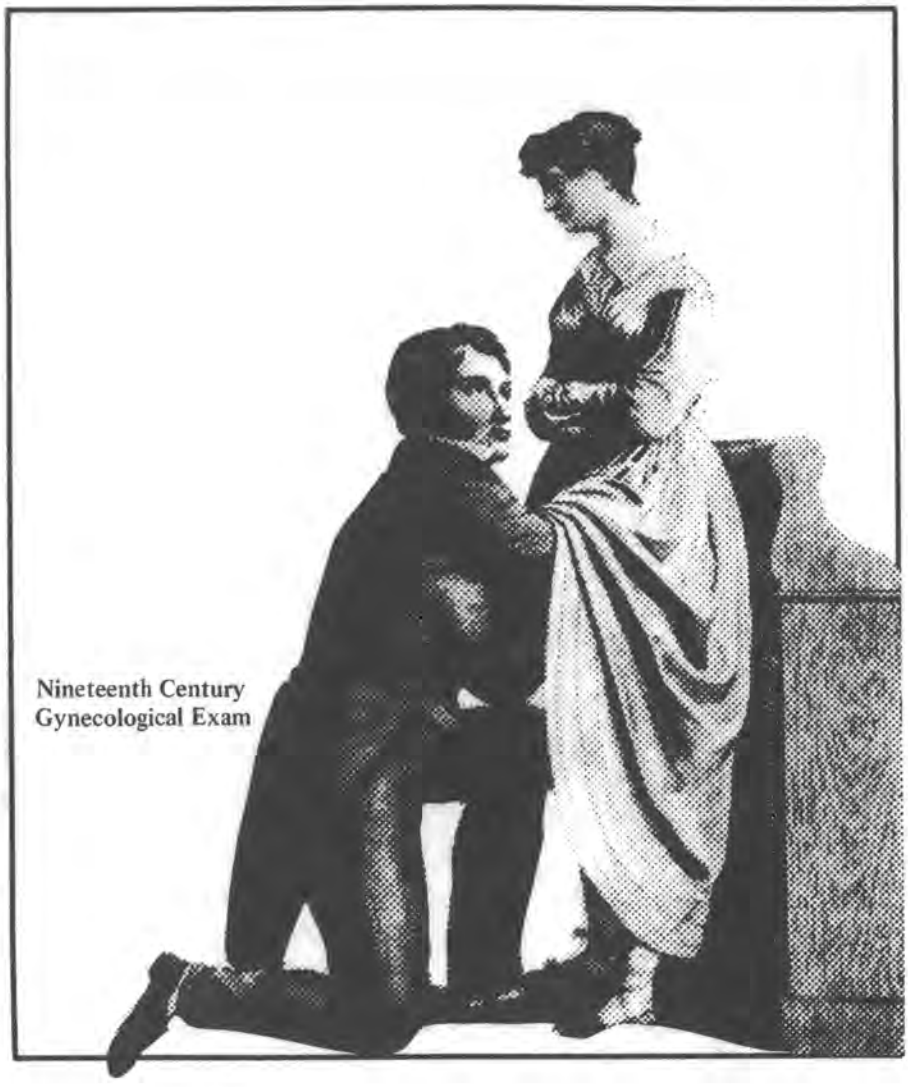
Linda: In March, 1974, we first offered abortion services and pregnancy screenings, both founded on the idea of Self-Help. We don't just provide services that women need; we do so in a way that the person can make as many decisions as possible in a clinic setting. We try to provide as much health information as a woman wants. And pregnancy screening is something we feel is very important for women's health groups to provide because it is run completely by lay women, with women doing the tests themselves, with assistance from health workers. Women can very quickly determine for themselves whether or not they are pregnant and share information about what they want to do about it.

In November, 1975, we started a gynecological clinic called the Well-Woman Participatory Clinic, which is a concept developed at the FWHC in Los Angeles. This is a setting with a group of women, health workers, and either a nurse practitioner or a doctor – we have a nurse practitioner. We demonstrate vaginal self-examination, and during the two hours, everything gets done that the women participating want done – a pap smear, a gonorrhea culture, a pelvic exam, a sickle-cell anemia text, after-abortion check-up, pre-natal care. Most of what is done at the Well-Woman Clinic are health techniques that can be done by the person herself, or with the assistance of the health worker, and with a bare minimum of instruction.

Marion: One of the goals of our Well-Woman Clinic is to share information in such a way that women gain skills and knowledge. Maybe next time they won't need to visit the clinic for simple things like a vaginal infection.

Q: What is a Self-Help Clinic?

Susan: Instead of the traditional medical clinic, a Self-Help Clinic is a group of women who meet together to learn about our bodies, and how to maintain our health by sharing information and skills with each other.



Nineteenth Century Gynecological Exam

Risa: Women in Self-Help Clinics share a caring responsibility for the women in their group. The Self-Help Clinic is a strategy whereby women can regain reproductive control.

The most blatant obstacle to accountability to the health needs of the community is the unresponsive hospital board.

Marion: Without control of our bodies, we can't gain control of our lives. Many times a Self-Help Clinic can get started and continue to meet. A natural progression for an advanced Self-Help Clinic is to start a women-controlled health center. That's what happened in Atlanta. The Self-Help Clinic women decided, after meeting together for about a year, to open a Feminist Women's Health Center.

Q: Are health workers as reliable as a doctor?

Susan: Yes, perhaps more so. Let's take pap smears, for example. What takes training is not the ability to take cells from the cervix wall, but to look at the cells and determine if there are signs of cancer. And no doctor does that; the doctor sends the cells to a lab, which is what we do, of course. We also provide a lot of health information on how to maintain your own health, home remedies and referrals over the phones.

Q. What is menstrual extraction?

Linda: It is a technique that was developed by Carol Downer and Lorraine Rothman of the first Self-Help Clinic in Los Angeles in 1972. We use the term to refer to a technique, used in advanced Self-Help groups, to gently suction the contents of the uterus on or about the first day of a woman's menstrual cycle. Menstrual extraction is always done by women together, not as a service, but in the spirit of sharing skills, information and experience. What is used is a very simple device that Lorraine Rothman developed called the Del'Em.

The woman having the menstrual extraction is in control of what happens. Menstrual extraction can be used for a number of different reasons. It can be used to rid oneself of an impregnated ovum, and it can also be used to regulate the menstrual cycle, which is a real boon for women who want to have regular periods or who may want to get pregnant. It can also be used to alleviate menstrual symptoms. This is still an experimental technique because we have not been able to get formal research done on it. Some physicians have attempted to co-opt it by adding the term menstrual extraction to the list of procedures done in their office as a service: menstrual regulation, pre-emptive abortion, endometrial aspiration, mini-suction; but menstrual extraction is clearly not a medical procedure and should not be confused with any of the previously named procedures. Other physicians have made statement after statement referring to it as a dangerous technique, because it is done by lay women, even though there is *no* evidence that it is harmful.

Meanwhile, lay people are being trained to do menstrual regulation by the International Fertility Research Project (IFRP) in Chapel Hill, NC, which is the world's leading birth control research facility, in order to control Third World populations.

Q: What is the relationship of the Tallahassee FWHC to the other FWHC's?

Marion: The FWHC's have formed a Federation to solidify our working relationships and to recognize that we are all working towards the same goals. The Self-Help Clinic is at the base of each FWHC. Members of the Federation of FWHC's are centers in Los Angeles, Orange County, Chico, San Diego, – all in California – and Atlanta and Tallahassee. We also work to share our collective resources and to avoid unnecessary duplication of efforts.

Risa: The exciting thing about the FWHC's is that we can travel to any center, walk in and feel right at home.

Q: It is my understanding that a community health group has developed. Can you tell us about it?

Linda: Yes, a group called Government Accountability to the People, or GAP, has been active now for about seven to eight months. GAP grew out of the Tallahassee FWHC's struggle to get a transfer agreement with Tallahassee Memorial Hospital; it involves a diverse cross-section of Tallahassee citizens, including the black community, since many of the worst policies at the hospital affect black people and their health care – issues such as the denial of treatment to a young black woman who was raped, coercion of poor and black people to take out loans to pay for health care, possible violations of the hospital's use of charity funds, differential treatment between blacks and whites in the emergency room, racist and sexist employment practices, and a strong union busting history by the hospital. The most blatant obstacle to accountability to the health needs of the community is the hospital board, which is elite and unrepresentative. You must be a landowner to be appointed. People from GAP have been going to board meetings and talking to people from the community, exposing the ties among the hospital and other institutions, their oppressive nature and lack of accountability to the human needs of Tallahassee citizens.

The FWHC started out as a single issue group in that we were very concerned as women with health problems. But after years of working on that single issue, we realized we could exert only a certain amount of power as a group and could do only certain things on that level. Some of us have children, and we see how the school system is doing things to them that we don't feel is good for their lives. We have to deal with the courts for arresting people from our community for doing nothing. We have all these other things to deal with that cannot be dealt with just by having a Self-Help health group. In realizing that, we decided to get involved in other issues to challenge other controlling forces in our lives. So we are working with a number of other groups locally.

Marion: We've learned that if you start with the Self-Help spirit, you can learn many things from other people that you need to know in order to survive. I have seen things develop since I've been at the health center that are incredible leaps of learning – the skills that it takes to administer a women's health facility and manage the books and talk to hundreds of women a week on the phone about anything they may be interested in, as well as run a clinic that hires fifteen or more people. The Self-Help concept is really the key to the whole thing. □

Lee County, Ark.

Building a Base for Reform

by Dan Blumenthal

Lee County, Arkansas, is 200 square miles of flat farmland on the bank of the Mississippi River in the mid-South Delta. Seventy miles to the northeast, across the river, is Memphis, Tennessee; 120 miles to the west, Little Rock.

Of Lee County's 18,000 inhabitants, over half are poor and about sixty percent are black. About a third of the population lives in Marianna, the county seat and only settlement with more than 300 residents.

On the outskirts of Marianna, in a field near an okra shed, stands a low square brick building – the Lee County Cooperative Clinic. An unusual health-care facility, it primarily serves the poor, and is one of only a handful of American rural health centers which attempts to provide comprehensive services. It is also unusual because it has been controlled from its inception entirely by the people it serves. But it is perhaps most unusual because of the central role it has played in changing the political and social outlook of Lee County.

Dan Blumenthal teaches in the Department of Preventive Medicine and Community Health at Emory University School of Medicine, and is Medical Coordinator of the W.T. Brooks Clinic, a public hospital satellite clinic in south Fulton County, Georgia.

The clinic exists, in large part, because of a pilot VISTA (Volunteers in Service to America) health project assigned to the county in August, 1969. As a doctor fresh out of internship, and the only physician in VISTA, I joined the project, along with my wife, Janet (a child psychologist), a nurse, and four other volunteers who had been given some basic training in health or community development-related areas. We had no specific assignment when we arrived in Lee County, other than to learn our way around and meet some of the prominent citizens.

We found an area largely bypassed by the civil rights movement. Ten years after Little Rock, *de jure* school segregation persisted in Lee County. Nearly two years after Dr. Martin Luther King had been gunned down only seventy miles away in Memphis, there was no evidence of his movement in Lee County. There was no SCLC chapter. There was, to be sure, an NAACP chapter, at least on paper, but it was all but invisible. It had been three years since Winthrop Rockefeller, a moderate Republican, had replaced Orval Faubus as governor of Arkansas, thus making the state a charter member of the "New South." But in Marianna, County Judge Haskell "Hack" Adams led an all-white county government that kept Lee County squarely in the ranks of the Old South. Adams, who once indicated to a visiting journalist that he thought blacks were genetically indolent and irresponsible, most symbolized the attitudes of the ruling whites.

As we drove around the county, we viewed a scene archetypical of rural poverty in the cotton South. Outside of town, there were scattered plantation houses, usually large, brick ranch-style structures owned by white gentlemen farmers. Down the road from a plantation house was, typically, a collection of tumbledown wooden shacks inhabited by the black field hands. Sometimes, instead of wooden shacks, there were small whitewashed cement-block houses.

The homes of the black farmers who owned or rented a small piece of land were generally indistinguishable from those of the field hands. Living in similar shacks were the elderly blacks and poor whites too old to farm

and too unschooled to do anything else, who lived on social security checks or on food stamps or, seemingly, on nothing at all. Typically, their houses were located on dirt roads that became impassable when it rained. Paved roads were few. Indoor plumbing was a rarity.

"An organization built around health care could serve as the basis for a successful political organization."

In Marianna, blocks of middle-class white homes alternated with blocks of blacks' unpainted shotgun houses which could have been moved in from the country. The few middle-class black houses were often owned by workers at the Douglas and Lomason auto seat-cover factory, the county's only industry. A statue of General Robert E. Lee, after whom the county was named, watched over the courthouse square.

Health care in Lee County was not plentiful, even for those who could afford it. Of the four doctors in Marianna, all general practitioners, one was in his mid-sixties, another in his mid-eighties. Counting all four, the physician-population ratio in the county was about a fifth of the US as a whole. The new twenty-five bed Lee Memorial Hospital had been built largely with federal funds. A county health department, staffed by an elderly public health nurse and a younger part-time public health nurse, provided well-child and prenatal care, and VD treatment. The nearest "charity" hospital and clinic for the poor was across the state line in Memphis.

Dr. Dwight Gray – one of the four doctors, and a prominent citizen – taught me what Lee County was about. When I first met him, he leveled with me as a fellow Southern doctor, one of the clan. "Feller from Pennsylvania was visiting down here a couple of weeks ago," he said. "Wanted to know why I've got segregated waiting rooms. I told him it was because that's what the colored folks want." He paused. "He just didn't understand," he added with a wink. I was beginning to understand.

Small Beginnings

As our first activity, the VISTAs organized four Neighborhood Action Councils (NACs), local grass-roots organizations that would represent the area in OEO* programs which had just become available to the county. One of the NACs was to be centered in Marianna, the others in small communities in three corners of the county. Knocking on doors, making announcements in churches, putting signs in store windows, we recruited people to NAC meetings which discussed local problems and their possible solutions. Talk at our meetings generally turned to health, not because it was necessarily the most important problem faced by the county's poor, but because a VISTA team was now available to attack it. The leading health problem, it was generally agreed, was the lack of a place where poor people could go when they were sick.

Stories abounded of people turned away from the hospital or doctors' offices because they lacked the means to pay for their care. Most people, however, knew better than to seek medical attention when they had no money. At one NAC meeting, I asked how many people had ever needed medical care but failed to go to the doctor because they could not afford it. Virtually all of the fifty or so people in the room raised their hands.

The VISTAs had been discussing health issues among ourselves, and we were committed to the idea of a community-controlled clinic. The legislation establishing OEO had called for "maximum feasible participation" of the poor in projects sponsored by the agency, but there was no consensus as to what this meant. "Community control" often existed more on paper than in reality. Now that the demand for a clinic in Lee County was apparent, we began to discuss at NAC meetings how such a facility should be planned and run by the people it served.

Why community control? There were several reasons. The first had to do with insuring the appropriateness of the services to be provided. The rural poor understood their own needs and priorities better than we, a group of urban professionals and middle-class college graduates, possibly could.

*the federal Office of Equal Opportunity

A second reason related to breaking the "cycle of poverty" in which perhaps half the citizens of the county were trapped. Generations of blacks in the Delta had depended on the charity of wealthy whites for much of their livelihood. If they were field hands, they lived in shacks provided by the plantation owner. Their kids wore his children's discarded clothes. If they needed to see the doctor badly enough, the plantation owner would pay the bill or the doctor would take on a "charity case." More recently, this patronage had become institutionalized as welfare and food stamps. The poor survived, but just barely, and only at the sufferance of the rich.

If people were ever to escape from poverty, we thought, they needed to get control of their own lives. It would not be enough simply to have health care, or other services, available; people needed to gain some of the self-esteem that accompanies the ability to dictate one's own destiny. Poor people needed broader political power, the chance to elect public officials, the opportunity to have a voice in the operation of the schools, the ability to direct public services, the power to have a meaningful voice in the daily affairs of the county. An organization built around health care could, we hoped, tackle other issues; it could serve as the basis for a successful political organization. If people saw that they could work together to gain control of one aspect of their lives–if they could develop and run their own health care facility–then they could take collective action in other areas as well.

The idea that the people who used a clinic should dictate such matters as hours of operation and fees to be charged made sense to the NAC members. By November, the four NACs had each elected two representatives to the eight-member Board of Directors of the unborn Lee County Cooperative Clinic. The board applied to OEO for an operating grant for the clinic, but the chances of approval appeared no better than fifty-fifty. The board, therefore, launched a community fund-raising effort to start the clinic on a shoestring if necessary.

In the meantime, we had begun running a "clinic" from my car, making house calls. This helped us

develop relationships of mutual trust between the VISTAs and the poverty community. I had also applied for membership in the four-member Lee County Medical Society, because membership carried with it staff privileges at Lee Memorial Hospital. But by now, the local doctors no longer considered me a member of the clan. By majority vote, I was refused medical society membership and the use of the hospital, including its laboratory and x-ray facilities.

By mid-November, 1969, the story of the rejection hit the papers. "Medical Society Locks Out Physician To Poor," read a headline in the Memphis *Commercial - Appeal*: "Dr. Mac McLendon, a Marianna physician, said the medical society refused Dr. Blumenthal admittance partly because he had 'agitated' local Negroes to demand more rights." In a subsequent newspaper story, Dr. Gray explained, "We object to a group financed by the federal government coming into the community and, in effect, practicing medicine as a group."

Over the next few years, similar situations would emerge in places such as Epes, Alabama; Holmes County, Mississippi; and Franklin, Louisiana. Southern rural doctors were concerned about shortages of health services in their communities, but they were more concerned about maintaining the existing health care delivery system and the existing political power structure. Government-financed doctors and clinics controlled by poor people, particularly by blacks, were not welcome. Organized medicine, which maintained control of hospital privileges and licensure, and which could often veto federal projects at the local level, could erect formidable roadblocks to innovative health care programs, if not destroy them altogether.

National media coverage of the Lee County situation soon led to rapid polarization of the community. The pharmacists, the minister of the First Baptist Church, some of the large farmers, and other white establishment figures lined up publicly against the VISTA project and the proposed clinic. The black community, on the other hand, solidified its support. The fund-raising drive produced nearly $2,000, mostly in one and two dollar donations contributed at church functions. Attendance at NAC meetings grew. The poor, who had for so long been recipients of paternalism and the beneficiaries of occasional charity, began to realize that the Lee County Cooperative Clinic would not come into existence of its own accord, the way other government programs had. A struggle would be required.

The board of directors of the clinic appointed a committee to negotiate with the board of directors of the Lee Memorial Hospital and the medical society for staff privileges for me and future clinic doctors. When it became apparent that the negotiations were at an impasse, a class action suit was filed in federal court, with the patients of the Lee County Cooperative Clinic as plaintiffs.

The Clinic Opens

OEO granted initial funding for the Lee County Cooperative Clinic (a relatively miniscule $39,875) in December, 1969, after three board members and three VISTAs went to Washington for a day to lobby the agency's officials. We were pleasantly surprised and speculated that perhaps OEO thought things could be kept quiet in the Delta by infusing a bit of health money. If that was the reasoning, the agency could not have been more mistaken.

In February, 1970, the board of directors selected as clinic administrator Olly Neal, Jr., a twenty-eight-year-old black who had been born and raised in Lee County. With only three years of college and no formal training in health administration, he appeared, on paper, less qualified than the other applicants for the position. But none of the others had ever lived in Arkansas, and Neal knew Lee County and its people; he could learn administrative functions quickly, and he was an incredible organizer.

Like other young blacks with ability or ambition, Neal had left Lee County years before to seek his fortune in the city. And like others, he had become disillusioned with urban life. But there were few opportunities in the country – one could become a teacher, a preacher, or a farmer. So, Neal had become part of the rural "brain drain." The job as administrator at the Lee County Cooperative Clinic gave him a chance to come home. He quickly became a major force in enabling the clinic to survive and make an impact on the county.

The clinic opened in March, 1970, with a staff of seven employees in addition to the VISTAs. It attempted to provide "comprehensive" services – more than medical care – for it was clear that malnutrition, poor sanitation, inadequate housing, lack of transportation and poverty itself caused

the poor health of the low-income population as much as did the inaccessibility of doctors. To combat malnutrition, the clinic assisted people in registering for the food stamp program, despite an often apparent desire by the local food stamp office to reduce its rolls. In addition, the clinic provided outreach and home care through three "neighborhood health aides" (local women trained by the clinic); transportation via a single van and driver; and assistance in constructing sanitary privies and doing home repairs from a VISTA experienced in this area. At the same time, I saw about thirty to forty patients a day in the clinic.

The volume of services we could provide was minute compared to the need, but it established the principle of providing comprehensive care. We specifically wanted to start small, to begin with a facility that could be effectively governed by a board of unsophisticated community people. Other OEO health centers, rural and urban, were multimillion dollar facilities run by universities or health departments with community "advisory boards" which were to be phased in as governing boards when and if they gained the necessary expertise to run a large center. We thought it far preferable for the community to govern fully a small facility from the beginning and for the clinic to grow as the board and the community grew in sophistication.

The clinic's bylaws defined it as a cooperative, with each registered patient a member of the cooperative and a part-owner. At an annual membership meeting, the administrator and medical director would report on the clinic's progress, plans, and financial status, and elections for the board of directors would take place.

Neal's commitment to this approach was total, and his organizational efforts on its behalf, tireless. He talked to people about the clinic – what it was, and what it could be – in his office, at NAC meetings, at board meetings, and in the little country bars that dotted the county. And sometimes there was a political message in what he said: if the county officials did not support this clinic, then perhaps replacing *them* would have something to do with health.

The clinic opened in a rented five-room house. Finding a place to rent had been difficult. Several vacant white-owned houses and offices, and even the abandoned Missouri-Pacific railroad depot, had suddenly become unavailable when the VISTAs had attempted to rent them as a clinic building. The five-room house belonged to the town's black funeral parlor director, one of the few wealthy blacks in Lee County.

In July, 1970, I had to leave Lee County to serve in the US Public Health Service, an obligation I had incurred in order to avoid the draft. Our major anxiety was alleviated when Dr. Ralph Wolf – a young physician recruited through a poster displayed in in a New Orleans hospital – replaced me. In September, when OEO increased the budget to $120,000 for the next year, the Neighborhood Action Councils voted on what new services should be added.

The summer of 1970 also marked the appearance of the Concerned Citizens of Lee County, a political organization whose leadership largely duplicated that of the Neighborhood Action Councils. As its first effort, the new organization sponsored a slate of seventeen black candidates for Marianna and Lee County offices in the November elections. It was the first such slate to appear on a Lee County ballot since Reconstruction, and excitement ran high at the clinic – at least until election day. All but four of the black candidates lost, and those four were elected to Justice of the Peace seats (similar to county commissioner), the least powerful of the positions sought. The black candidate for County Judge had lost by 400 votes out of 6,600 cast. The election was marred by some intimidation by whites of black voters at the polls while the sheriff looked the other way, but while these incidents left a bad taste in the mouths of black voters, they probably had little effect on the outcome of the election.

Despite the losses, signs of black political power were evident. The Concerned Citizens' candidates had run as Republicans in order to avoid a primary contest with the Democratic incumbents. The black Republican vote, combined with the votes of ticket-splitting whites, had enabled the

Republican Winthrop Rockefeller to carry Lee County in his race for re-election as governor. It was one of the very few counties he carried, as Democrat Dale Bumpers won in a landslide.

The appearance of a black slate of candidates kindled racial fears in the whites of this majority-black county; at the same time it gave the black community a feeling of some potential political muscle. Then, in April, 1971, the white power structure suffered another jolt when the Lee Memorial Hospital Board agreed to an out-of-court settlement of the clinic's suit demanding hospital staff privileges for clinic doctors. The hospital consented to the agreement when it realized it would lose its suit if it went to trial.

Boycott

Three months later, Quincy Tillman, a young black social worker employed by the county welfare department, got into an argument with a white counter-man over what flavor of pizza she had ordered. The dispute grew heated and Tillman was arrested. In days gone by, the incident might have been overlooked, but now the black community, particularly the Concerned Citizens, was in no mood to ignore further injustices. The Concerned Citizens proclaimed a boycott of all white-owned downtown Marianna businesses and declared that the boycott would continue until a list of forty-one demands, mostly for more jobs in both the private and public sectors, was met.

By January, 1972, a dozen stores, a third of the downtown business district, had closed. Racial tension ran high and spilled into the school system when black students in the newly-integrated high school demanded of the white superintendent of schools that the birthday of Dr. Martin Luther King, Jr., be declared a school holiday. Refused, the black students – eighty percent of the enrolled students – walked out of school en masse and began a protest demonstration. The police and fire departments arrived, turned a fire hose on the students in sub-freezing weather, and arrested one hundred of them. With injury added to insult, the black students declared a school boycott that lasted the rest of the term.

For the first time since the organized black political activity had begun in Lee County, violence reared its ugly head. County Judge Adams, driving a pickup truck, narrowly missed running over two black boycott picketers on the sidewalk in downtown Marianna. (Later, he testified that his brakes had failed.) When the two picketers went to the county courthouse to file charges, Adams threatened them with a pistol. Cooler heads restrained the County Judge and he was eventually arrested, convicted of assault and carrying a prohibited weapon, and fined $100.

Subsequent incidents were more serious. The house of one of the boycott leaders was fire-bombed; shots were fired at another boycott leader. In January, the headquarters of the Concerned Citizens was burned; the fire spread, destroying ten businesses, seven black-owned, three white-owned. Another white-owned store burned a few weeks later. A white deputy sheriff was shot at and his house fire-bombed. A shot was fired at the president of the school board. Miraculously, despite the numerous incidents, there were no deaths, no serious injuries.

White attention focused on the Lee County Cooperative Clinic, and on Olly Neal, Jr., in particular, as the moving force behind the boycott. Said a white shopkeeper, whose store had been put out of business by the boycott, "I've been in this business thirty years in this one building, and we never had any trouble until *they* (the clinic) came in here." The head of the Lee County Farm Bureau added, "Olly Neal is involved in a lot of racial things. He headed the boycott, led people to school board meetings and he was instrumental in the store burnings, although I can't accuse him individually of doing it."

As a clinic administrator, Neal was more than a paper-pusher. He was an organizer and an articulate spokesman for the black cause. But Neal did not have to head the boycott, lead people to school board meetings, or burn buildings. The black political organization did exist largely because of Neal's organizational efforts on behalf of the community-controlled clinic, but the organization thrived

in response to the opposition of the white establishment to the clinic. The boycott had been called as a result of years of bitterness on the part of blacks over their denial of entry into the county's political and economic system. And the violence stemmed from that bitterness, and from the whites' reaction to the sudden threat to their dominance.

The white establishment complained to Washington about the clinic's assumed role in the boycott and the county's politics, and Washington responded by investigating and auditing the clinic and its funds, the VISTAs, and Neal. No wrongdoing was found.

The clinic, meanwhile, expanded its staff and patient load. In 1972, OEO approved a funding request for $1.2 million for eighteen months. The grant would be enough to buy some land and construct a new building; to make the transition from clinic to comprehensive health center; to provide a volume of services more commensurate with the need. The white establishment was appalled that this thorn in its side would suddenly acquire a budget larger than that of the county government itself.

The Lee County White Citizens Council filed a suit in federal district court to block the grant. The suit focused on the VISTAs, charging that, "Because of the clinic's association with...VISTA, it has shown what appears to be a subversive attempt to overthrow or replace the presently constituted Lee County government with that of one controlled by blacks. In the past, VISTA has, by encouraging blacks and whites to participate in psychodelic [sic] parties and other mixed racial social events, fomented and disturbed racial relations in the county."

Meanwhile, State Representative J. B. Smith and School Board President Lon Mann pressured Governor Bumpers to exercise his power of veto over the HEW grant, or to approve it only on the condition that the clinic board be reconstituted to give the whites control. Bumpers temporized, trying to strike a compromise in the politically volatile situation. He summoned Neal and several members of the clinic Board to Little Rock and explained to them that he might be forced to cut off clinic funding if they would not consent to reconstitute the Board. Mrs. Emma Glaspy – a frail, middle-aged black woman from the tiny Lee County community of Brickeys, who might have been voted "the Board Member Least Likely to Stand Up To the Governor of Arkansas" – responded for the Board. "Mr. Governor, we understand your position, and we sure do need that money, but we just can't give our clinic away." It was a position that could only have been taken by a clinic board that had started penniless and knew it could go back to being penniless if it had to.

Besides, there were, perhaps, other resources, albeit small. As a start, Joan Baez accepted a clinic request to give a benefit concert in Memphis and raised about $6,000. Then in the spring of 1972, Bumpers finally managed a compromise: the clinic board would be enlarged by five members, giving the county fathers a minority interest in the facility. The bargain enabled the Governor to approve the grant without completely losing face. At the same time, he declared that "I wholeheartedly support the clinic," provided there was no "agitation" and no violation of federal requirements. Of the five new white board members, only one – a maverick who actually supported the clinic – participated in board affairs.

Reconciliation

The summer of 1972 brought a resolution to what had seemed an interminable struggle, and marked the beginning of a new chapter in the history of Lee County and the clinic. The school boycott ended as school let out. Moreover, the superintendent of schools resigned, removing a focal point of the boycott. The economic boycott of the downtown businesses, after sputtering for several weeks, was officially terminated on July 26 by the Concerned Citizens. The forty-one demands had not been met. The administrator of the Lee Memorial Hospital resigned and was replaced by Ken LaMastus, a white moderate who immediately set about repairing relations with the clinic. And the clinic began construction of its new 7,000 square-foot building.

Some things did not change. In November, a slate of black candidates once again ran and failed to capture any of the major county offices. Two years later, Olly Neal, Jr., ran for the State Legislature; he, too, lost.

But the threat to the white business and economic community was diminished, as was the threat to the clinic. With the lessening of the threats came a lessening of the overt racial tensions. In 1974, more moderate whites replaced County Judge Adams and Sheriff Courtney Langston, symbols of hard-line white dominance. And in 1975, the Memphis *Commercial Appeal* wrote, "The Lee County Cooperative Clinic, once clearly a symbol of racial strife and violence, is now as clearly an accepted part of (Marianna)." Perhaps symbolic of the clinic's acceptance was the small sign in Neal's office proclaiming the clinic to be a member of the Marianna-Lee County Chamber of Commerce. Neal himself, declaring that the now million-dollar facility required a more highly-trained administrator, resigned his position to become director of the clinic-affiliated Demonstration Sewer and Water Project which he had been instrumental in establishing to build sanitary water supplies and sewer systems for rural Delta homes.

Acceptance did not spell an end to the problems faced by the Lee County Cooperative Clinic. Foremost was the problem of recruiting and keeping physicians. Most doctors are trained and socialized in medical school to become private specialists in the suburbs, not salaried primary-care providers serving the rural poor. The new building had been constructed to accommodate four doctors, but at times staffing dwindled to as little as one doctor and one physician's assistant.

Second was the problem of maintaining adequate funding. HEW, which had taken over OEO health programs, increasingly stressed private-practice medical models at its health centers, both urban and rural, cutting back on outreach services and on programs which attacked the health-related problems of sanitation, nutrition, transportation, and housing. Neal's tenacity in dealing with federal officials ("You've just got to out-argue the sons of bitches") played a key role in preserving support for the full range of services offered by the clinic. Still, the clinic became less comprehensive year by year.

Nor did the end of the racial conflict in Lee County and the end of the threats to the clinic's existence signal an end to the problems of the

county's poor. No doubt, health care had improved markedly. Some inroads had been made into the health-related problems that the clinic's broad range of services was designed to attack. But the poor were still poor.

When the VISTAs began organizing around the prospect of a clinic, we were engaged in a war on poverty. We were not running a poverty program; we were running an antipoverty program. Viewed from a distance, it is clear now that a community-contolled clinic in one county cannot lead to the elimination of health problems or poverty. But the clinic did far more than make the poor of Lee County a bit healthier. The clinic helped create a new psychology in the county, a change in the collective consciousness of the black and the poor community. By working together, the poor got something – a clinic – that they did not have before. In doing so, they had acquired enough power to make some changes in the county, enough to gain the respect of the establishment and, more importantly, enough to gain self-respect.

The white community, too, changed. No longer could the black majority be overlooked or dismissed with a glib, "We ain't got no race problems here." Whites gained, if nothing else, a new appreciation of what it meant to be a black in the Arkansas Delta. Even State Representative Smith, who had led the white effort to close the clinic in 1972, was able to say in 1975, "Our community is a lot better today because of the boycott and what we went through then." It was an incredible statement.

I returned to Lee County for the first annual membership meeting of the clinic in November, 1971, and for the sixth annual meeting in November, 1976. The first meeting drew over 600 people. The clinic was under attack then, and the community was rallying to its support. In 1976, fewer than 100 people attended the meeting. To the outsider, the sparse attendance might have signaled a loss of support for or interest in the clinic. But the clinic had, by then, become an established part of the county, and a visible show of support was no longer needed. The clinic had served out its role as a focal point for change in Lee County. It was still more than just a health care facility to the community it serves, but it was no long an institution of social upheaval. The 1960s were finally over. Lee County, with the rest of the country, might or might not move further ahead in the 1970s, but it could never go back. □

photo by Earl Dotter

Who Will Pay the Bill?

by Joyce Goldstein

Joyce Goldstein is the executive director of Health Service Action (P.O. Box 6586, T St. Station, Washington, D.C. 20009), a group organizing for national health service and in support of local struggles to build community-controlled health care facilities. It is headquartered in Washington and has affiliates in several states and cities across the country. Local and statewide health service advocacy groups are forming in Illinois, Pennsylvania, California, New York, New Jersey, and Washington, D.C.

Howard Price loves to tell visitors to Cedar Grove, West Virginia, that he's just a "dumb coal miner." Would that we were all so "dumb"!

An electrician by trade and a working miner, Price is also the coordinator of the Miners Committee to Save Our Clinics and the president of his community clinic, the Upper Kanawha Health Association. In the summer of 1975, he and seven friends each contributed $1.25 to incorporate the Association. By September, 1978, the paltry investment of $10 will have mushroomed to $1,000,000 to finance their vision of a community health facility.

They've already located the clinic in a freshly painted, gold-carpeted school which they purchased with money from the federal government. The first floor of the old, neighborhood school had been almost entirely renovated for the clinic by February, 1978. But the community center atmosphere remains. The school gym is still intact, and one can generally find a basketball game or a union local meeting behind the doors which separate the gym from the clinic.

It hasn't been easy establishing a clinic in Cedar Grove. Howard Price can remember how every nickel and dime was raised: from community rummage sales, bake sales, the Appalachian Regional Commission, the county court, private foundations, the federal government, and many neighbors and friends.

The biggest help, however, has come from the Health and Retirement Funds of the United Mine Workers, the union Price belongs to and the union that touches

photo by Earl Dotter

the lives of most families in the Cedar Grove area. Of the 9000 county residents, almost half are active or retired miners and their families. About seventy percent of the people who have visited the clinic since it opened in June, 1977, have been beneficiaries of the UMWA Health and Retirement Funds. Eight percent receive Medicare or Medicaid, and another twenty percent are either covered by private health insurance or have no insurance. No one is denied care because they can't pay for it; but prior to the UMW Funds cutbacks in July, there was little need for "charity medicine." The Funds made it financially possible to operate the clinic and keep it controlled by a board, seventy-five percent of whose members must be miners, according to the Association bylaws. (None of the eighteen board members are women, Price admits with embarrassment.)

It has taken more than just money to get the clinic into operation. In order to be eligible for public funds, the clinic had to first receive a "certificate of need" from the local health planning agency. The local authority pointed out that another clinic existed right across the street from the school. Housed in a trailer, the privately owned Hygeia Clinic boasted one physician on its staff. Price and other community residents were unimpressed. "After twenty years they had just one doctor," he recalls. "That ain't progress."

A team of experts from Columbia University found that the Hygeia Clinic provided only curative medical treatment, made little use of non-physician providers, and had no community control over its practices. So the Upper Kanawha Association pressed its bid for approval from the health agency – and, after a long fight, the clinic was okayed.

The next fight was to staff the clinic with doctors from the National Health Service Corps, and once again, the clinic needed an official seal of approval. The Corps is a system which places young doctors in communities lacking adequate health care services, after these doctors have completed government-subsidized medical training. But the local medical society must approve the program before any doctor can be assigned to an area. Despite the fact that the county had only three doctors (one was over seventy), the Charleston and Upper Kanawha County Medical Societies maintained there was no need for additional doctors – and refused to allow the clinic to obtain the services of National Health Service Corps physicians.

Price and his friends took the case to higher authorities. After two years, the federal government overruled the medical society. Soon there will be a medical doctor and a dentist from the National Health Service Corps at the Cedar Grove clinic. The clinic can then provide community people with a full range of "primary care" – everything short of hospitalization. Plans for the next three years provide for increasing the staff from seven to fourteen, with all on salary and having input into daily decision-making and personnel policy. In addition to offering traditional medical care, the clinic plans to provide home health services, health education, social work, x-rays, physical therapy, nutrition services, occupational and environmental health advocacy, inhalation therapy for miners (many of whom suffer from black lung), and continuing education for the staff.

But the empire-building schemes, dear to the hearts of many professional health care administrators, make no sense to Howard Price. Asked if he wanted to purchase new equipment to provide high technology care and in-patient services, he replied: "We want the best primary care. Our machines are used. Why should our patients have to pay for expensive equipment that nobody uses?"

The Funds Die

While a sense of pride and accomplishment exudes from the staff and the community board, the battle for survival has barely begun. The first major blow was dealt barely a month after the clinic's birth. On July 1, 1977, the UMW Health and Retirement Funds – which provide about seventy percent of the clinic's monthly income – reversed a twenty-five-year-old tradition of commitment and support for clinics in mining communities. Upper Kanawha is only one of about fifty miners' community clinics dependent on the Funds for their financial security.

As Helen Lewis from the Highlander Center says, "These clinics are the most progressive tools for providing health care in the area....Rural health problems include environmental and living problems such as water quality, sewage, diet, housing and occupational hazards. Community health clinics provide a local structure through which these problems can be considered."

The Funds reimbursed the clinics through a "retainer" system, providing a percentage of the clinics' total monthly operating costs equal to the percentage of the clinics' clientele who are UMW Funds beneficiaries. The reimbursement procedure was based upon the clinics' total costs – which include maintenance, staff salaries, equipment and supplies – rather than on the traditional fee-for-service formula. Thus, the clinics have been able to provide a wide range of services delivered by physician and non-physician teams, and have been able to

keep the fees low for patients who are not beneficiaries of the UMW Funds.

Fee-for-service medical practice, on the other hand, pays providers for every service they deliver; there is an incentive to provide more and more – even if it is unnecessary, wasteful, expensive, and sometimes harmful.

As of July 1, 1977, the Funds announced they were going broke and were replacing the retainer payment system with a fee-for-service system that required miners to pay the first $500 of their medical bills from their own pockets. The coal fields exploded as 80,000 miners went on wildcat strikes to protest the cuts in benefits. Howard Price formed the Miners Committee to Save Our Clinics, and some twenty clinics created the Associated Clinics of Appalachia to have a unified voice in fighting the cutbacks.

In a statement from the clinic association to the Funds on July 26, Don Conwell from the New Kensington Clinic (Pa.) explained: "By having the retainer arrangement, many areas were able to hire doctors because they could guarantee them a salary. With the withdrawal of the retainer and the ultimate collapse of these clinics, these doctors in many cases will leave and areas that are already underserved will be worse off and miners will be unable to obtain good medical care....It is mind-boggling to try to understand why the innovators of a system that they have fought for and worked for would turn away from their own concept at a time when the rest of the nation is realizing that this is the best way to go....We plead with you, don't take away the best and most progressive health care program in the nation and throw it into the expensive control-free fee-for-service market."

Price, as spokesman for the Miners Committee to Save Our Clinics, appealed to Harry Huge, the union's representative and chairman of the Funds: "You seem to think that making it difficult to see a doctor for these people will save the Funds money. Of course, it will not save money. Our children will grow up less healthy, and there will be more severe illnesses among our older people which will require more hospitalization....Preventive health programs are being killed because they just cannot be supported on a fee-for-service basis....You have opened the gates for the rip-off artists who run patients through like cattle and thrive on your fee-for-service philosophy....You are making us pay for health care that will be harder and harder to find."

And the Funds responded. Martin Danziger, the Funds' administrator, wrote to Price, "Please be assured that our commitment to the clinic system is undiminished." Harry Huge echoed, "The Funds remain committed to the outpatient care model and the prepaid clinics built around that model. There has been no change in our philosophy, nor in our long range plans."

The miners finally went back to work after gaining a promise that the Funds' coverage would be renegotiated.

The next blow came on December 6, 1977, the expiration date of the 1974 contract between the UMW and the Bituminous Coal Operators Association and the beginning of the longest coal mining strike in American history. All payments from the Funds to the clinic stopped, with little hope of ever being revived. The clinics were forced to lay off health workers. Medical staffs which had been developed for twenty-five years in the older clinics began to disintegrate. The process of killing the clinics was exacerbated. And people suffered. Many patients stopped all visits to the clinics. And many clinics provided medical care wth little hope of ever being reimbursed.

At this writing, there is every reason to believe that the UMW Health Funds will be discontinued and replaced by private insurance companies. How will this move affect the clinics? Most insurance companies reimburse only physicians and on a fee-for-service basis. Therefore, the teams of health workers, consisting of physicians, physicians' assistants, nurse practitioners, nutritionists, health educators and social workers, will almost surely be destroyed. Mountain communities which have had such hard times trying to attract physicians will have even harder times. And ancillary personnel won't be eligible for reimbursement from the insurance companies. In order to maintain these health teams and their services, fees will have to be drastically increased and the clinics will enter the private, inflationary, irrational market system. Or services will be severely curtailed.

Is there any hope for the clinics' survival? While the older, larger clinics may be able to adjust to the new situation, the prospects for the younger, smaller community clinics such as Cedar Grove are less encouraging. As long as the existence of the clinics is dependent on a single industry, their survival will continue to be tenuous. But this bleak picture of the future of the clinics assumes that there will be no change in national health policy. It assumes that the only actors on the stage are the UMW, the coal operators, and the clinics. This, clearly, is only one piece of the total federal health picture.

Although the clinics could not get special Congressional action for their own salvation, a new national health policy could dramatically affect the miners' predicament. The Carter Administration has promised national health insurance. But "national health insurance" is a very general expression which can mean little more than the government contracting out to the private sector for the delivery of health care to some part or all of the population. It could mean little more than an expansion of the Medicare and Medicaid programs.

National health insurance, regardless of the specific program, is only a way to pay for the current health care system. It intentionally does little to change it.

The Dellums Bill

Could a national health insurance program save the clinics? Maybe. Depending on the specific legislation that would be passed by the Congress, such a program would certainly subsidize, to a lesser or greater extent, the already established clinics. But in order to support the existing clinics and build on their positive experiences by developing similar community-based health care facilities around the country, there must be a federal commitment for a national health service where communities have the money to hire health practitioners, build health centers and develop community programs according to their own needs and priorities.

As Congressman Ronald Dellums (D-Ca.) told Howard Price and the American Public Health Association last October: "It is time to begin the fight for a national health service by recognizing the most immediate needs while organizing the political support to ensure the only meaningful long-term solution."

Dellums has introduced the Health Service Act, to create a national health

photo by Earl Dotter

West Virginia miners await tests for black lung disease in Beckley.

service to be financed entirely out of progressive federal tax revenues. The Health Service Act would replace the entire profiteering health care industry with a system that would be publicly controlled. The United States Health Service would be a tax-supported public agency providing a complete range of health services to the entire population in publicly-owned facilities.

As envisioned in the Dellums bill, USHS has a four-tiered structure:

- At the "Community Level," there will be primary care services – general outpatient care, emergency services, mental health care, and programs for occupational health and safety and environmental monitoring. These will be provided by community health centers and other local facilities – controlled by elected boards, consisting of two-thirds users and one-third health workers. Structures like the miners' community clinics would provide the base of the system.
- Serving the larger "District" will be the general hospital for inpatient services. The district-level hospital will be governed by a district health board whose members will be chosen by each of the community boards.
- Several districts will join together as a "Region" to set up a specialized medical center and the health worker education system.
- The national level will supervise specialized research and overall budgeting and financing.

Controlled at every level by democratically elected boards, the Health Service will maintain strict cost and quality controls over health care, using many of the techniques demonstrated by the miners' community clinics.

Health care will no longer be the private preserve of self-employed, self-regulated, self-selected – and entirely unaccountable – "professionals." Instead, health care providers will be salaried workers – like you and me. Salaries will be in line with experience, education, and the nature of one's job, and the rigid hierarchy of health care occupations will be eliminated.

For the individual user, health care will be free, just as it was for the miner and his family who carried the cherished UMW medical card. No longer will the doctor, clinic, or hospital ask the barbaric question, "How much can you pay?"

Health costs for the entire society will also be reduced. No longer will we pick up the tab for the administrative costs of insurance and billing procedure; for the unnecessary treatments and hospitalization encouraged by fee-for-service medical practice; or for excessive profits and astronomical incomes of the professional elite.

Meanwhile, unlike the present medical licensing system, the Health Service will continuously review the performance of health care personnel, with both consumers and health workers participating in the evaluations. Instead of medical schools dominating public health care facilities through affiliation contracts, as is the practice now, the Health Service will encompass the educational facilities. The new health care system will provide health workers with continuing education to maintain and improve their skills.

The Dellums Health Service Act also includes a patient's "Bill of Rights" designed to sensitize the entire health care system to the special needs of groups which have been abused by the existing health industry.

The Bill of Rights guarantees:

- Access to all health services
- Choice of health care providers
- Advocacy and legal assistance
- Clear information and explanations, in one's own first language, about one's health and proposed treatments.

The principles for a national health service are already backed by the United Electrical Workers, the American Public Health Association, the Gray Panthers, the National Association of Social Workers, Rural America, and other organizations, as well as by thirty-one percent of the American public, according to the latest Harris poll.

While the reality of a national health service is still a dream, the nightmare which faces the miners' community clinics is only too real. In building a movement for a national health service, we cannot sit by and watch the execution of the clinics' death sentence, nor can we settle for the bureaucratic tinkering which may allow the clinics to squeak by as only shadows of their community health service potential.

The immediate hardships must be seen in a more general framework. Fighting for piecemeal reform from the government, the union, the Funds, or the operators, can, at best, ameliorate the most pressing, short-term needs. But what happens when the grant expires, the National Health Service Corps doctor moves to suburbia, the union goes out on strike, the Funds become managed by self-serving lawyers, and the companies reinstate the company doctors or use health care as a club with which to threaten coal miners, their families, and their communities?

The crisis of the miners' community clinics represents the crisis which is being experienced in health care throughout the country. The entire country must hear and identify with the desperate cries of the Appalachian people. If not, then as Don Crowell of the Clinic Association warns, "Once again the forgotten people will be the mountain families who mine the coal that keeps this nation going." □

Lessons from Community Clinics:
Good News and Bad News

by Helen M. Lewis

The community-controlled health center offers the best hope for primary medical care, improving the health of the residents and improving the quality of life in rural, poor or minority communities. However, such clinics or centers are not developed without struggle, and some of the difficulties and pitfalls which await should be understood and squarely faced.

Stability: Community health centers provide a stable source of health care. Even when there is a turnover of health professionals, there is still stability through local boards and a permanent place for the patients' medical records.

BUT – Patients grow weary of the turnover and uneasy about who is looking at their records and providing care. If communities are to develop stable professional staffs, they must recruit local people, develop scholarship programs and pressure medical schools to admit them.

Practitioner-Staffed Clinics: Areas which can not attract or economically support a physician can use local primary health practitioners to provide services, and even without professional staff, the centers can provide education, screenings and referrals.

BUT – The practitioner-staffed clinic can be just another way of providing poor and rural areas with second-rate service. The redistribution of health professionals and facilities is not addressed, and the highly trained still go to the more prosperous, urban areas.

Not-For-Profit Medicine: The non-profit clinic employing all staff on a salaried basis is less costly; savings can go toward extra services such as home health counseling.

BUT – The clinic competes with the for-profit health system and may have difficulty getting the necessary approval from local medical associations, certification for "corporate practice," admission to the medical society and hospital privileges for clinic physicians.

Service-Oriented Practice: The centers attract more idealistic, service-oriented physicians and practitioners.

BUT – The demands on time for them are so heavy and the multiple, chronic problems they face so overwhelming that many of them "burn out" in a couple of years. The professional isolation and lack of opportunity for continued professional development is a drawback especially in solo practice, and even the most committed may leave with considerable guilt feelings.

Government-Foundation Funding: HEW, ARC, and foundations such as Robert Wood Johnson provide generous start-up funding for rural health centers.

BUT – For some, the goals and standards which are required can not be sustained. It is extremely difficult to resist the offered treasures, and even more difficult to give them up later.

Community Control: Operation of the health center with community boards allows the community to plan and control their health care.

BUT – Some professionals will not share their expertise or assist boards in developing the necessary skills to manage the clinics. Some boards will not commit the time and effort to cope with budget details, operational procedures and staff relationships. Funding sources, regional HSA planners and other health consultants take away much of the community board's power. Health centers must develop educational programs for the boards so they can acquire the skills to control their centers' operations and destiny.

Community Development: Community clinics can lead to other spinoffs. Since health is non-controversial, it is an issue which can unite citizens and act as a lever for other community development projects. As citizens learn to unravel federal-grantsmanship and become more sophisticated in building institutions, they may move into other projects like roads, water systems, sewage disposal, and housing.

BUT – If the activity becomes controversial and the local power structure sees the community clinic board and its spin-off activities as a threat, they may attempt to take over the board and change its direction.

Health Model vs. Medical Model: The health center emphasizes a broad approach to health; it is designed to deal with preventive care, education for health, early treatment of sickness and promotion of community development projects to upgrade life in general.

BUT – It may be considered as a "charity" clinic only for the poor. With patients limited to those without funds or insurance, the clinic lacks needed fees; but seeking to serve middle and upper classes may change the clinic's approach to health. A service-oriented operation may be reluctant to enforce collection policies, and may allow the staff to provide services for free which could be reimbursed. On the other hand, a clinic which attempts to achieve self-sufficiency may become less sensitive to the needs of poor people and more concerned with providing expensive, profit-making care. There is a constant tension between providing good service and survival.

Despite the problems, the community health center still offers the best hope for health care for communities.

But it is important to understand their fragile position in the health system and the numerous barriers to their survival. They are like small islands in a troubled sea. Clinic boards and consumers should be uneasy, run scared and work for more thorough-going change in health care structures to make possible good health care for everyone. □

Helen Lewis directs the Health Project of Highlander Center, which attempts to aid the development of clinics in Appalachia and to design educational programs for their board and staff members.

Lessons from Community Clinics:
Conflict and Democracy

by M.H. Ross

Most Americans go to the offices of private physicians to receive their care in health and illness. For many, this is a satisfactory encounter even though the physician alone determines the fees, procedures, and hours he is available – indeed, every aspect of the relationship. But for those who may wish to improve or criticize the way in which health care services are delivered, there is little opportunity for discussion or bargaining as equals.

The patient is invariably in a poor position to engage in bargaining: he or she may be horizontal on an examining table, in a state of undress and anxious about the health care problem that prompted the visit. The result is that most people only have the alternative of voting with their feet: they can go to another doctor (if one is available in the rural community) or to another institution.

In the last decade, increasing numbers of clinics and health centers have opened in which the people of the community have some serious say-so about how it is run. Such organizations have varied greatly from rural nurse practitioner clinics to small family practice medical groups to large multi-specialty clinics. Some were organized out of struggles over issues in the community, while others were the fruit of an individual's or organization's concept of an improved health care delivery system.

Some health centers resulted from efforts of student and activist groups such as those at Vanderbilt and those who joined VISTA, while many are a direct response to federal programs like the Rural Health Initiatives. The dozen Rural Practice Project models with which I work are a much smaller demonstration of primary care in isolated rural areas. Some of the older Appalachian coal miner clinics were a consequence of leadership by the medical care program of the UMW Fund, and gradually made a transition to broad and representative board control. More recently, smaller clinics came about because of demands of the coal miners and their families.

In terms of total money and personnel, all such clinics and health centers in the country are but drops in the bucket in an enormous system which has successfully resisted change for decades. Yet the neighborhood health center movement pioneered health care teams, outreach staffs which included family health workers, and an approach toward comprehensive health services which embraced the usually neglected areas of transportation, social services and mental health.

Broad community representation on the boards of many of the new health centers has resulted in a sensitive response by physicians and other providers to the needs of the people in the community. Programs of care, as a result, have often been improved and broadened. At Fairmont Clinic in West Virginia, the lay board successfully called for and negotiated with the physician group to achieve a wide program of social services and outreach, all-day Saturday and evening physician hours at the clinic and the development of pharmacy, podiatry, optometry and optical services.

In some places the democracy of community control has worked out like a beautiful marriage in which there *is* conflict, but also discussion and respect resulting in cooperation and compromise. In other cases, each faction on the board, or the spokesperson for the board and the professionals, begin their angry responses with "you people" – which is usually a good signal that things have broken down into "us and them."

Frequently, board members represent different interests and may have values and attitudes which differ from other community representatives as well as from those of the professionals. Power struggles may take place, not only between the community board and health care team members, but between differing community interests.

If there has not been a clear determination of what the role of the community board is and where the limits lie on the authority and responsibility of professionals, there is likely to be professional and administrative uncertainty throughout the organization. Indeed, some of the representative community boards for National Health Service Corps projects, RHIs and other federal programs spend a great deal of time and energy trying to resolve internal relationships and conflicting opinions. Although participation in decision-making can lead to individual development as well as an increased sense of social responsibility, often the HEW constraints requiring breadth of community representation are not followed up with a program for training leadership and educating boards on the policy issues they will encounter.

The excessive conservatism of most physicians is ideally balanced when the community has an opportunity for representation in the delivery of health services. As more and more doctors turn toward group practice, it has become apparent that the old idea that these medical groups, by themselves, would somehow benefit patients equally with physicians has proved to be a myth.

Because the nation has not yet achieved a national health service program or national health insurance, it is important that there be continued experimentation with different models to determine the best ways to serve the health needs of the community. Increasingly, the federal government will come up with regulations governing the clinics and health centers despite the very different needs of their communities and the origins of their structure and organization. Whether it is a bread-and-butter issue, like a single pattern for Medicaid reimbursement, or the direction a national health service program should take, it is essential that there be debate and discussion about improved community representation in health care and the variety of ways to deliver that care to the people. □

M.H. Ross is associate director of the Rural Practice Project in Chapel Hill, North Carolina.

photo by Earl Dotter

The Rise and Fall of the UMW Fund

by Barbara Berney

"THEIR JOY AND GRATITUDE CAN ONLY BE IMAGINED"

"What the doctors from the UMWA Funds saw was beyond belief – paralyzed men (paraplegics) who had not been out of bed for two, eight, seventeen, or twenty years, the story of their pain and despair deeply written on their faces. Bladder and bowel control had often been lost with the injury, and they were unable to care for their simplest needs. The men described their pain – 'It's just one deep, lasting ache,' or 'It hits me about three or four times a day, like someone jabbing a big electric rod through my legs.'

"Some were in windowless shacks, fed and cared for by their neighbors. Others were cared for by devoted wives and other members of the family. Some had not seen a doctor in years. All required the entire time of one or more other persons to keep them alive and provide such limited assistance as untrained hands could give.

"If was explained to these men and their families that the Fund was prepared to send them to some of the leading medical centers of the country, where everything possible would be done to relieve their suffering and develop and train their broken bodies, so that they might be able to move about and care for themselves. In some instances, it was suggested that they might be able to learn some new kind of work for which they might be paid. When they finally realized that they were listening to the truth, their joy and gratitude can only be imagined. . . ."

– excerpted from an early UMW Fund Annual Report

photo from Wide World Photos

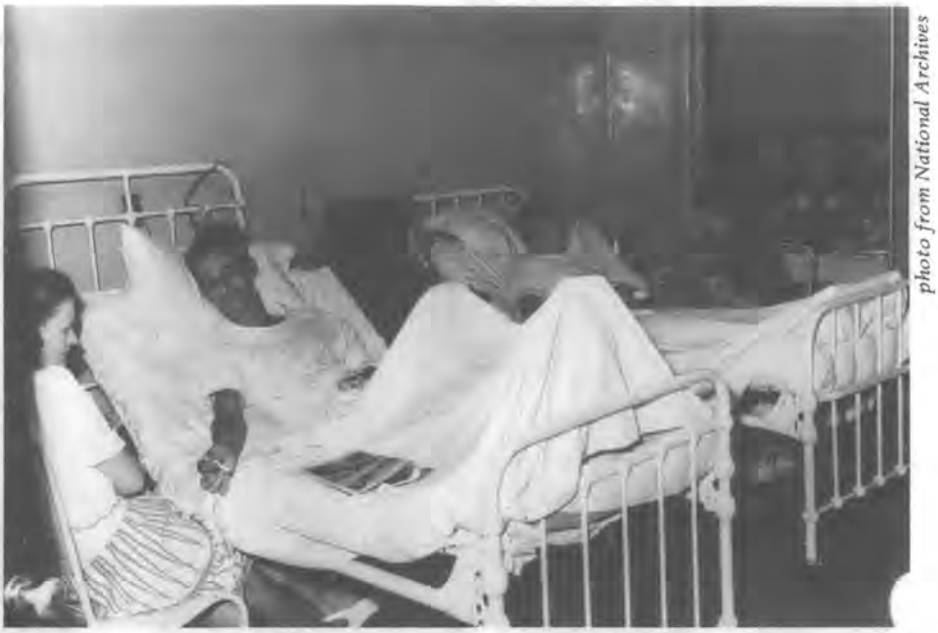


photo from National Archives

John L. Lewis – After President Truman seized the mines in 1946, Lewis won control of health care in negotiations with the government's representatives.

When the doctors from the UMWA Health and Retirement Fund first set foot in the Appalachian coalfields during 1949, they found themselves surrounded by the human wreckage of a medical disaster area. Mangled bodies, discarded by the coal operators, were piling up. Health care, hospitals, physicians and sanitation were unknown to many of the neglected mining families nestled deep in the mountain hollows. When limbs were severed or a sickness lingered, miners in the coalfields had but one choice when they needed care – the infamous "check-off" doctor. Since the mountains had always been medically underserved, coal operators made regular deductions from the miners' paychecks to guarantee a steady income for the coal companies' chosen physicians. These "check-off" doctors made no regular examinations, but by their arrangements with the coal companies, they owned a monopoly on health care in the mountains.

John L. and His Fund

This medical monopoly was finally broken in 1946 when UMWA president John L. Lewis negotiated a contract providing for a royalty of five cents per ton of mined coal to support a union-controlled Health and Retirement Fund. The contract agreement came only after negotiations with the coal operators became deadlocked, and President Truman seized the mines. In negotiating with the government's representative, Interior Secretary Julius Krug, Lewis won his demand for a health fund coal royalty which the industry had rejected during the previous year's negotiations. The historic Krug-Lewis agreement also ordered a survey of medical and sanitary facilities and health conditions in the coalfields.

Nowhere were the detrimental effects of the operators' policies on miners' health better documented and exposed than in *The Medical Survey of the Bituminous Coal Industry,* conducted under the direction of Navy Admiral Joel T. Boone. Commonly called the Boone Report, this study represented the first comprehensive medical survey of an industry ever undertaken by the government. By cogently documenting the deficiencies of coal operator-controlled health care in the mountains, it laid the essential groundwork for developing a miner-controlled health care financing and delivery system. The Boone Report cited a wide range of medical and environmental problems, pointing out the undesirability of the "check-off" doctors, the inadequacy of three-fourths of the coalfield hospitals, and the glaring deficiencies in transportation, housing and sanitation in mining communities. Especially in the southern Appalachian region, the report noted that primary care was provided by an insufficient number of inadequately trained and poorly motivated physicians and that specialist care and hospitals were simply not available.

The creation of the industry-financed Health and Retirement Fund by Lewis made the coal operators financially responsible for the health and welfare of miners and their dependents, from the cradle to the grave, and started a revolution in health care delivery throughout the coalfields in the South and Midwest. Bargaining for the Fund came at a time when World War II wage controls forced the UMWA to develop innovative benefit demands at the bargaining table. Over the next several years, Lewis gradually upped the coal operators' royalty payments and gained increasing administrative control over the Fund itself.

By October, 1952, the Fund's royalty payments had been increased to forty cents per ton; Lewis was now chairman of the Fund's three trustees, and his close confidant, Josephine Roche, occupied the key position of neutral trustee. In day-to-day administration, this arrangement gave the union decision-making control, but as Lewis noted at the time, "the operators' veto power on this fund rested in the fact that at the end of each con-

Barbara Berney, who holds a Masters in Public Health from UCLA, was employed by the UMW Fund as a health analyst until January, 1978.

tract period they could, if they would, discontinue it by refusal to continue it."

And there were other drawbacks. By tying the Fund's financing directly to the industry's production output, Lewis had made the miners' health and welfare benefits vulnerable to the boom and bust cycles of the coal industry. Throughout the history of the Fund, the cruelness of this irony has haunted miners in the coalfields, particularly during the early '50s, when the coal operators began to introduce mechanization to increase productivity. In the process, many miners lost their jobs to machines – machines which made coal mining more dangerous for the miners who remained by increasing both the safety hazards and the dust levels in the mines. Ironically the Fund's improved financial status, and the subsequent development of a revolutionary health care program in the coalfields, were accompanied by increasing industry-caused health and welfare problems for miners and their communities.

Serving the People

As the newly appointed Executive Medical Officer of the Fund, Dr. Warren F. Draper came with impeccable credentials both in public health and organized medicine. He had served as Deputy Surgeon General of the US Public Health Service and as a member of the American Medical Association (AMA) House of Delegates from 1924 to 1946. His credibility and stature were to prove invaluable to the Fund in its struggle to provide "comprehensive, accessible, quality care at reasonable cost" to miners and their families throughout the coalfields.

Draper began by opening area medical offices in ten locations throughout the coalfields. Each medical office was directed by a physician administrator who was directly responsible to Dr. Draper and his staff. These physicians comprised one of the most progressive groups of health care professionals of their day and were committed to establishing a model health delivery system based on prepaid care.

Their first task, and one of the boldest and most stirring efforts of the Fund, was to seek out the broken and disabled miners and provide them with previously unheard of rehabilitation and medical care. A vast campaign involving union officials, local record searches, and the questioning of knowledgeable local citizens was undertaken to locate mine accident victims. Once found, crippled miners who had not been out of bed for months, years, and even decades were carried, in stretchers, by friends and ambulance crews, to places reachable by vehicles, which were then driven to the chartered planes and Pullman cars which transported them to the best rehabilitation centers of their day.

According to Dr. Draper, "This arduous, costly task of restoring men with crushed limbs and backs in the terrible toll of the coal mines is one of the finest chapters in the history of medicine." By the end of 1955, 97,000 disabled miners had received rehabilitation services. About 6,500 of them had been able to return to the industry; 15,000 found work in other industries; 5,800 became self-employed. Of 1,113 who had spent their lives in bed before getting such care, 1,041 were enabled either to walk or get around in wheel chairs.

When Draper and his administration began, they conformed strictly with the practices of traditional, doctor-dominated medicine. Free choice of physicians was the rule and services were paid for in fees. But as the Fund's area medical offices reviewed bills and medical records from doctors, they began discovering myriad abuses, similar to those presently associated with Medicare and Medicaid – unnecessary surgery, over-hospitalization, and price gouging.

The Fund created by Lewis started a revolution in health care delivery in the coalfields.

Draper wasted little time in explaining his position to his former colleagues in the medical establishment. In a speech before the AMA, he set forth basic principles which would guide the operation of the UMW Fund in the years ahead: "I think that free choice of physicians should be limited to physicians who are willing to conserve the resources of the paying agency to the fullest extent possible. It is not reasonable to expect us to pay physicians who needlessly send to the hospital cases which do not require hospitalization and whose rates of admissions are much higher than the rates of other competent physicans. We are within our rights to limit our choice of physicians to those who are willing to conserve the resources of the Fund and play fair with us." The UMW Fund's precedent-setting efforts to secure high quality care at a reasonable price angered both coalfield physicians and doctors across the country.

As protests from local coalfield medical societies became more vehement, the Fund stopped its automatic reimbursement of doctors' fees and hospital charges and began an ambi-

photo by Earl Dotter

photo by Earl Dotter

tious program to reform health care delivery with a three-pronged attack on excessive hospitalization costs and monopoly control of coalfield health care.

First, the Fund began to replace the uncooperative coalfield doctors by organizing and financing, with the help of union locals, a series of group practice clinics throughout the mountains to provide coordinated, comprehensive primary health services to the Fund's beneficiaries and other members of the coal mining communities. These non-profit clinics, run by consumer boards representing the local communities, were staffed by physicians who were either paid regular salaries or put on a monthly retainer to cover all necessary care provided to Fund beneficiaries. The clinics stressed preventive medicine and became the first one-stop medical service centers in rural America. As a result, they reduced hospitalization, surgery, and overall medical costs.

Next, Draper ordered that no Fund beneficiaries would be hospitalized unless approved by a qualified specialist, in order to avoid unnecessary surgery and prolonged hospitalization.

For the third prong in its attack, the Fund tackled the problem which the Boone Report had so forcefully documented – the lack of hospitals in southern Appalachia. The Fund set up a non-profit corporation to finance the construction of ten hospitals throughout Kentucky, West Virginia and Virginia. The Miners' Memorial Hospitals were a bold step forward in the regional planning of health services and they were touted as a first for the rural South, as well as a model for the nation and the world. Provision for large outpatient services and hospital-based ambulatory care – a cost-saving innovation at the time – was a central concept in both their construction and operation. The first hospital opened its doors in December, 1955, the tenth in May, 1956. In addition to providing sorely needed, well-equipped modern beds and sophisticated diagnostic and therapeutic facilities in areas essentially devoid of these services, the Miners' Hospitals made it possible to recruit and train high quality health professionals for Appalachia, many of whom were the sons and daughters of coal miners. Other hospitals in the area improved their facilities, while some of the smallest and most wretched were forced to close.

In reponse to the Fund's vigorous intrusion into health care delivery in the mountains, state and local medical societies passed resolutions condemning Draper and the Fund. Some doctors refused to refer their patients to the Miners' Memorial Hospitals. In areas where the miners' clinics were established, local medical societies tried to ensure that clinic physicians were systematically denied hospital privileges in local hospitals.

For example, physicians associated with the Fund's Bellaire clinic in Russellton, Pennsylvania, were not able to obtain local hospital privileges from 1952 until 1965. During the thirteen year interim, they were forced to send patients needing hospital care to Pittsburgh. When the Fund removed the hospital from its participating list, the medical staff accused the physicians and the Fund of pressuring the hospitals and their staffs "to accept the dictatorship of the UMWA Fund." In an advertisement in the New Kensington daily newspaper on April 21, 1959, the medical staff of the Citizen General Hospital accused the Fund of depriving "the individual of one of his precious American 'Rights' – 'The right of free choice.' The power hungry leaders of this and similar movements in our country today preach free enterprise...but they are working for...false socialized economic security...and socialized medicine."

In one of his more candid moments, a local doctor called the clinic physicians, "a bunch of young punks come out here to try [to] cut into my $30,000 a year practice." In a letter to Les Falk, Area Medical Director for the UMW Fund, the president of the board of trustees of the City Hospital of Bellaire commented on the removal of four physicians from the participating list: "It is beyond our comprehension how an outside agency such as the United Mine Workers Fund should or can take upon itself the prerogative of judging the quality of medical care provided by these physicians and overriding a committee of their peers."

In 1963, after having been denied privileges for more than ten years, Bellaire Clinic doctors and some of their patients finally instituted suit against the City Hospital of Bellaire, "its trustees, the medical society and various individuals, charging them with conspiracy in restraint of trade, violation of public policy and violation of the Ohio Valentine Antitrust Act." This suit was finally won in 1965. The court directed the hospital to grant privileges to the group members. Local and state societies fought back by charging the

clinic medical groups, their individual members and Area Medical Administrators with unethical conduct, including allowing the Fund to control their practice of medicine, soliciting patients, and denying patients the right to "free choice of physician." In every case, these charges were eventually proven false or dropped, but by then organized medicine had developed other strategies of attack. In Pennsylvania, Indiana, and Illinois, state medical societies wrote all their members directing them not to deal with the Fund. Despite this pressure, most coalfield doctors continued to treat beneficiaries and bill the Fund.

The Fallout

When the bottom fell out of the coal industry in the late 1950s and early '60s, the number of UMWA miners dropped from 400,000 in 1945 to 200,000 in 1955 to 90,000 in the early '60s. As a result, fewer and fewer patients in the Miners' hospitals were Fund beneficiaries and the hospitals became an ever-increasing financial drain on the Fund, which was already experiencing financial difficulties due to decreases in production and a royalty rate that had remained at forty cents per ton since 1952. The Fund initially responded to the financial crunch by tightening eligibility requirements. In 1960, 35,000 miners who had been out of work for more than a year lost their health cards in a single day, along with thousands of widows and other dependents.

Still suffering from financial problems, the Fund put the Miners' Hospitals up for sale in 1962. The Board of National Missions of the United Presbyterian Church purchased the hospitals for $8 million, almost all of which was provided by the federal government after the personal intervention of President John F. Kennedy. Had Medicare and Medicaid been available then, the Fund might have been able to keep the hospitals. As it was, neither federal aid, which made possible the purchase of the hospitals, nor state aid, which paid for indigent patients in the hospitals once they were acquired by the Board of Missions, were offered the Fund.

Rank and file miners, who were never consulted about this giveaway of one of their most valued possessions, carried on wildcat strikes to protest the Fund's decision. As if it were a harbinger of an event still fifteen years in the future, the union leadership turned a deaf ear to the miners' cries, as the foundation of their cherished health care system was sold out from under them. During its first twenty years of operation, the UMWA Health and Retirement Fund developed and pioneered more innovative ways to control the cost and quality of health care that are only now being re-discovered and recommended by health advocates and reformers across the country. The Fund developed a closed panel of participating doctors who, by accepting reimbursement from the Fund, were cooperating with a regional program of comprehensive care, consumer control, and hospital use and cost containment. At the same time that the Fund pioneered and financed the first consumer-controlled comprehensive health clinics and first independent regionally coordinated hospital system that rural America had ever seen, it also contained the cost of health expenditures.

The Fund's role in improving the occupational health and the general

photos by Earl Dotter

Dr. Donald Rasmussen, left, in his black lung clinic. Rasmussen was one of the crusaders in treating black lung; after 1946 the UMWA attracted the most progressive health care professionals.

Miners protesting fund cutbacks in August, 1977.

welfare of beneficiaries, was, however, much more limited than its role in improving the coalfield health system. Although Dr. Lorin Kerr did much of his early work on black lung under the auspices of the Fund, its involvement in occupational health issues was limited by the presence of the management trustee, by Lewis' commitment to labor peace and industry mechanization, and by his claim that the union itself was responsible for health and safety on the job.

The Fund also left such issues as housing, sanitation, water supply and sewage disposal to public health departments which were most often inadequate to the task, especially in southern Appalachia. The Fund's intervention and financial support began with preventive medicine and never really moved into environmentally-caused diseases.

Reform Effort

As the Fund income decreased and costs rose during the late '60s and early '70s, the corrupt administration of union president Tony Boyle manipulated Fund eligibilty requirements and benefits and maneuvered union finances for his own personal gain and to the detriment of the Fund and its beneficiaries. From his dual position as UMWA president and Health and Retirement Fund chairman, Boyle kept between 14 and 75 million dollars of the Fund's assets in non-interest bearing accounts in the UMW-controlled National Bank of Washington.

During the late 1960s, numerous suits were filed against the Fund and Tony Boyle. One of these, *Blankenship v. Boyle*, was brought by Harry Huge, a Washington attorney, on behalf of 17,000 miners and widows who charged the trustees and the union with mishandling the Fund's assets and the arbitrary and capricious determination of eligibility for Fund benefits.

In 1971, Judge Gerhard Gesell ruled in favor of the plaintiffs and ordered in part:

- That a new board of trustees be appointed with the neutral trustee subject to approval by the government.
- That the Fund have no financial dealings that would provide collateral advantages to either the union or the operators.
- That the application forms and process make clear that union membership is not required to obtain benefits.
- That eligibility for pensions was to be based on specified length of service requirements and applied in a reasonable and consistent fashion.

As a result of the Blankenship court decision and the Miners for Democracy reform movement led by Arnold Miller, drastic changes took place within the administration and structure of the Health and Retirement Fund. Shortly after Miller was elected president of the union in 1973, he appointed Harry Huge, the attorney who had fought for the Fund's reform, as the union representative among the Fund's three trustees. Huge, in turn, convinced the other two trustees to hire Martin Danziger, a lawyer administrator from the Justice Department, as the new director of the Fund.

Danziger and many of the other newcomers to the Fund were not trained in pensions, or health, or coal. Their speciality was a style of management defined as a service separate from the content of what is to be managed. And in some ways content became much less important to the Fund's health program than it had ever been. The new managers placed great emphasis on administrative documentation, written procedures, and the business-like conduct of affairs. While their attitude was quite understandable in light of the Blankenship decision, the Fund's new managers undervalued the skills and contribution of many who had forged and directed the Funds health program for twenty-five years.

Many of the old time health people were fired, downgraded, or simply resigned. There were tremendous conflicts in personality, working style and commitment between the old timers and the newcomers, and very little trust. As physicians and administrators left the Fund, they were either not replaced – the Fund was without a Medical Director for over a year – or replaced by people with more limited experience and a different orientation to health care delivery. Thus, when critical program decisions were made, such as the July, 1977, cutback in benefits, they did not reflect the Fund's historical commitment to the prepaid clinic/salaried physician model of care.

1974 Contract

The new management made significant changes in the organization of the Fund. Medical bill paying was centralized. It was determined that the kind of record-keeping required to comply with ERISA (Employee Retirement Income Security Act) and other information needs of the Fund could no longer be stored or processed adequately by hand. Because it seemed clumsy

and outdated to manually handle $250 million worth of health services annually, the Fund computerized its records in a crash program during the life of the 1974 Contract.

Any change so drastic as centralizing and computerizing the bill-paying and record-keeping functions of an organization as large as the Fund creates a degree of chaos. Payments to providers were slowed down, and control over services and charges – once maintained by looking at each bill coming into the Area Medical Office – was lost before the computer could provide adequate replacement data.

In addition to procedural changes, the new Fund management was reluctant to intervene in the health care system. Local offices were forced to relax their demands upon health care providers both because the Fund could no longer promise prompt and accurate payment, and because there was little support in Washington for strict cost controls. New management policies also forced a dramatic retreat from direct or personal health service to beneficiaries. The Fund had done case findings among its beneficiaries – originally to seek out miners in need of rehabilitation. Field staff had arranged for referrals and social services, visited miners in hospitals, made medical appointments, given personal health education and provided discharge planning. These services were systematically dropped as uneconomic and inappropriate for the Fund. Staff were instructed to find local agencies charged with these functions and refer beneficiaries to them. The Fund's role in providing technical assistance and special financial aid to providers was also sharply curtailed, further diminishing its role in the lives of beneficiaries. The Fund began to look more and more like other third party payers, like an "insurance company with a heart."

As a result of payment delays and mistakes, the Fund lost much of its credibility and clout with health care providers and with many miners. Its long history of active support and control over the community clinics was replaced by increasing scrutiny of costs, elimination of subsidies for the care of non-Fund beneficiaries, and an erosion of its faith in the efficacy of group clinics in favor of the standard fee-for-service solo practice.

In addition to the Fund's new management practices, restrictions in the 1974 Coal Wage Agreement further eroded its support both in the coalfields and in the public health community. The 1974 contract called for the division of the Fund into four separate Trusts. The 1950 Benefit Trust was established to pay for health care, death and survivor benefits for miners retired before December 31, 1975; and the 1950 Pension Trust paid pensions to these same beneficiaries. Two similarly divided 1974 Trusts were set up to pay benefits and pensions to working miners and miners retiring after December 31, 1975. The important thing about this division was that miners retiring under the 1974 contract divided Fund beneficiaries into two unequal classes in order to raise the pensions of working miners, while also forestalling a dramatic increase in royalties for the coal companies.

The Fund's new managers had no background in health or coal. Instead, they placed great emphasis on administrative procedures and computerized billing.

Divide and Conquer

Why was the Union willing to divide its membership? Why were the 80,000 miners retired under the 1950 Trust limited to pensions of $250 per month while 1974 beneficiaries were eligible for pensions averaging $425 depending on age at retirement and years of service?

When the 1974 Coal Wage Agreement was negotiated, the UMWA was having a difficult time organizing non-union mines – both the new strip mining operations in the Western part of the country and those in traditionally anti-union parts of Appalachia, particularly Kentucky. Operators at the non-union mines began telling their workers that joining the UMWA would mean shouldering the financial burden of the 80,000 retired miners covered by the Fund. Many non-union companies also increased their employees' wages by an amount equal to the health and retirement royalties required by the 1974 contract, giving them cash in hand instead of payments into the financially ailing Fund. The UMWA was further pressured by the realization that demanding pensions at the 1974 Trust level for all miners would have necessitated a royalty increase which would have driven marginally profitable union mines out of business, adding more problems to organizing.

As the 1974 contract went into its final year and a half, the 1950 Benefit Trust began experiencing severe financial difficulties. By the terms of the 1974 contract, reallocating money between the different Trusts was the prerogative of the coal operators and the union, not the three trustees of the Health and Retirement Fund. At a time when health care costs were rising and pensioners' buying power was falling, the Fund was placed on the chopping block between a strife-torn union and a profit-hungry industry.

In May, 1976, the union and the Bituminous Coal Operators Association (BCOA) agreed to stave off disaster by reallocating income from the 1950 Pension Trust to the 1950 Benefit Trust. Another reallocation in October, 1976, transferred income from the 1974 Benefit Trust, which had $60 million in reserves, to each of the other three Trusts.

This second reallocation played a critical part in the financial dealings which quickened the death of the Fund. Two aspects of the transaction appear suspicious. First, the trustees of the Fund requested only that income be transferred from the 1974 Benefit Trust to the 1950 Benefit Trust. Instead, the UMW and the BCOA shifted income from the 1974 Benefit Trust *to each of the other three Trusts*, completely eliminating two months of contributions to the more recent Benefit Trust.

Secondly, working miners incurred out of pocket expenses of $30 million for health benefits between July, 1977, when the benefits were cut back, and December, 1977, when the 1974 contract expired. Had the $60 million not been transferred, the health benefits of working miners could have been paid in full for the entire period.

photo by Earl Dotter

In early June, 1977, the coal operators refused to reallocate funds to stave off cutbacks a third time. Joseph Brennan, president of the BCOA, said that another reallocation would constitute "a stamp of approval for wildcat strikes" which were sweeping the coalfields. The coal operators claimed that the wildcat strikes were the cause of the Fund's financial short-fall, drawing attention away from their own miscalculations and punitive manipulations of the Welfare and Retirement Fund. Coal production – and therefore Fund income – was adversely affected by wildcats, a harsh winter and extensive flooding; but the largest loss of income was due to the coal operators' failure to open new mines that they had planned when the projections of Fund income were originally calculated for the 1974 contract.

On June 20, 1977, a few days after the close re-election of Arnold Miller, the trustees announced a cutback in health benefits in order to prevent a build-up of unfunded liabilities in the two Benefit Trusts. Beginning July 1, all beneficiaries would be responsible for the first $250 of a hospital bill, and forty percent of all non-hospital care up to $500 per family. In addition, all retainer arrangements with clinics and other providers were cancelled. Henceforth, all charges were to be billed on a fee-for-service basis.

The immediate response in the coalfields was a wildcat strike which involved some 90,000 miners for ten weeks. The clinics also protested, explaining that they would not be able to operate their programs on a fee-for-service basis and began to cut back on services and personnel.

The cutbacks themselves put the union in the humiliating position of entering the negotiating sessions for the new contract struggling to regain benefits that had already been won in the previous contract. The union leadership's inability to control wildcats and unwillingness to support them, plus the charges that the announcement of the cutbacks was timed to ensure Miller's re-election, further weakened the credibility of the union both with the BCOA and the rank and file.

Who Killed the Fund?

In retrospect, there is reason to believe that the coal industry intentionally orchestrated the financial crisis within the UMW Health and Retirement Fund in order to regain autocratic control over its workforce, break the power of the UMWA and, once and for all, rid itself of the financial burden of the human suffering of its workforce.

It appears that the Fund is dead as a provider of health benefits for the miners. The new contract allows each operator to insure its workers through private, profit-making insurance companies and provide them with the standard fee-for-service benefits which have created so many problems in the health system.

Since the Fund subsidized clinics throughout the coalfields (and consequently the care of much of the medically indigent population in these regions), and since it is extremely doubtful that any Blue Cross/Blue Shield, commercial insurance or other operator-sponsored plan will continue such subsidies, it is likely that many clinics will be forced either to drastically reduce their services or shut down completely.

The end of the Fund has implications beyond the health care system. For miners it may be the beginning of the end of national contracts. Portability of benefits – the ability to transfer health and pension benefits from one operator to another within the industry – may be threatened. And of course, neither the union nor the miners will have a say in the administration of company-provided benefits.

The UMWA Fund was one of the first industry-wide collectively bargained health plans in America. It attempted to establish a model health care system for workers in a single industry, and was successful in implementing innovative concepts in public health, including regionalization of care, comprehensive health centers, limited prepayment schemes, and the use of salaried physicians.

The Fund represents thirty years of history and practice in innovative rural health delivery and in struggle with organized medicine to improve health care. Those who continue the struggle have much to learn from that experience. □

Lessons from the Fund:
Band-Aids Don't Cure

by Matt Witt

Supporters of current national health insurance proposals believe that America's sick health care system can be cured without major surgery. The illness, as they see it, is simply lack of money; many people cannot afford medical help. Make sure everyone has insurance, then the people will be healthy.

If the experience of the UMWA Welfare and Retirement Fund is any guide, they're wrong.

When the Fund's health program was started thirty years ago, its medical director, Dr. Warren Draper, made a conscious policy decision not to challenge the health care structure in the coalfields. The Fund's only role would be to pay bills from medical institutions and doctors who would continue to work in their traditional way. Draper, who had been part of the AMA's highest ruling body for more than twenty years, believed that doctors must be allowed to make decisions about health care programs without interference from lay people.

As a reporter put it, writing during the heyday of the Fund and looking back on its early years, "Dr. Draper and his aides tried to play within the rules dictated by organized medicine.... Frustration was their usual reward." By 1950, the Fund's leaders realized that simply providing money for the existing system was inadequate in two ways: it didn't improve the quality of health care, and it didn't control costs. Many doctors were still putting profits ahead of patients' needs, and service varied greatly from community to community.

The Fund took a number of steps, the most important of which was supporting the creation of a parallel health care system, including a series of non-profit hospitals and clinics. Reform was never pushed far enough, in part because the Fund lacked national, governmental authority, but the Fund-inspired institutions demonstrated the importance of several principles on which a national health care system should be based:

• **Removing the profit motive.** Doctors and hospitals should not be in business, with their income dependent on how many operations or tests they can sell. At the Fund-backed, non-profit hospitals and clinics, doctors were put on salary, so decisions about patient care would be made only on the basis of medical considerations. In general, however, the Fund had to rely on the existing profiteers to provide care to mining families. Retainers were paid instead of fees-for-service, but that reform had only limited impact on the practices of profit-making providers, since retainers were periodically renegotiated based on services provided.

• **Giving the community control.** Decisions about the health care system are too important to be left up to doctors alone. Particularly in recent years, a few Fund-supported clinics were run by boards of directors elected from UMWA local unions and the community at large. As a result, the community had the final say on clinic policies, budgets and equipment purchases. "The community that uses the doctor hires the doctor," explained coal miner Napoleon Martin, a clinic board member at Gary, West Virginia, "so we know we're going to get good service."

Unfortunately, the Fund never fully used its influence to encourage community control. Miners and their families were not consulted on policy decisions at the Miners' Memorial Hospitals, including the decision to sell the hospital chain. Community participation on boards of directors was not made a condition of support for either public or private hospitals and clinics. Within the Fund itself, miners were never involved on the national or regional level. Benefit cutbacks, and even destruction of the Fund itself, were ordered behind closed doors by a handful of unelected professionals with no personal stake in the outcome.

• **Attacking the occupational and environmental causes of illness.** It is only logical that preventing illness in the first place is better than coping with its effects. In many cases, working or living conditions cause sickness, including black lung disease, hearing loss, stress, arthritis and back strain. Fund personnel did research on some of these problems, but because the solutions to them have been historically opposed by the coal companies, the UMW Fund did not agitate for change the way it would

---

Matt Witt, a writer in Washington, DC, is former editor of **The United Mine Workers Journal.**

have if epidemics of, say, polio or smallpox had swept the coalfields in similar proportion.

• **Providing complete coverage from cradle to grave.** Comprehensive coverage is not only a basic human right, but it makes good medical sense because many health problems are interrelated. Although some clinics were reimbursed for office visits and general examinations, the Fund generally did not support such care. The effect was to discourage patients from seeking help for problems that had not yet become serious.

The Fund largely ignored mental health, a major health problem in its own right and an important factor in physical well-being. Recreation, for instance, was not considered a Fund concern, despite the severe depression experienced by many retired and disabled miners who have few activities to choose from once their working days are past. Eye care and dental care, among the most important health needs, were also excluded from Fund coverage.

• **Coordinating programs nationally and regionally.** The US health care system needs planning and coordination to avoid duplication and insure equal access to health resources. The Fund showed in a very limited way how this can work. It built hospitals in the underserved areas of the southern Appalachian mountains. In some cases, it refused requests to finance new equipment because the same services were available nearby. But, again, it often lacked the authority to impose its plans on existing providers of health care.

• **Encouraging patient education and participation.** In order to help prevent disease, people must understand how their bodies work; how to regulate their diets and patterns of work, recreation and rest; why particular treatments are prescribed; and so on. The Fund encouraged a few clinic programs for education and counseling, but it was never a significant Fund activity.

• **Restructuring the medical profession.** Traditionally, the supply of medical personnel has been kept low. At a number of Fund-backed clinics and hospitals, programs were set up to encourage the training and use of nurse practitioners and other non-doctors qualified to administer many types of health care. Attempts were made to build links with medical schools and to draw more doctors to the coal regions. Group practice was encouraged to make more efficient use of doctors' skills and time. But in most communities, the existing system of private practice received Fund support without significant change.

The Fund, like the national health insurance plans proposed by some liberals, paid for health care for many people who couldn't afford it, and made some small reforms in health care practices. But the Fund ultimately failed because there was no effective movement to demand fundamental change in the national health care system.

Those who want to improve American health care today must learn that lesson. □

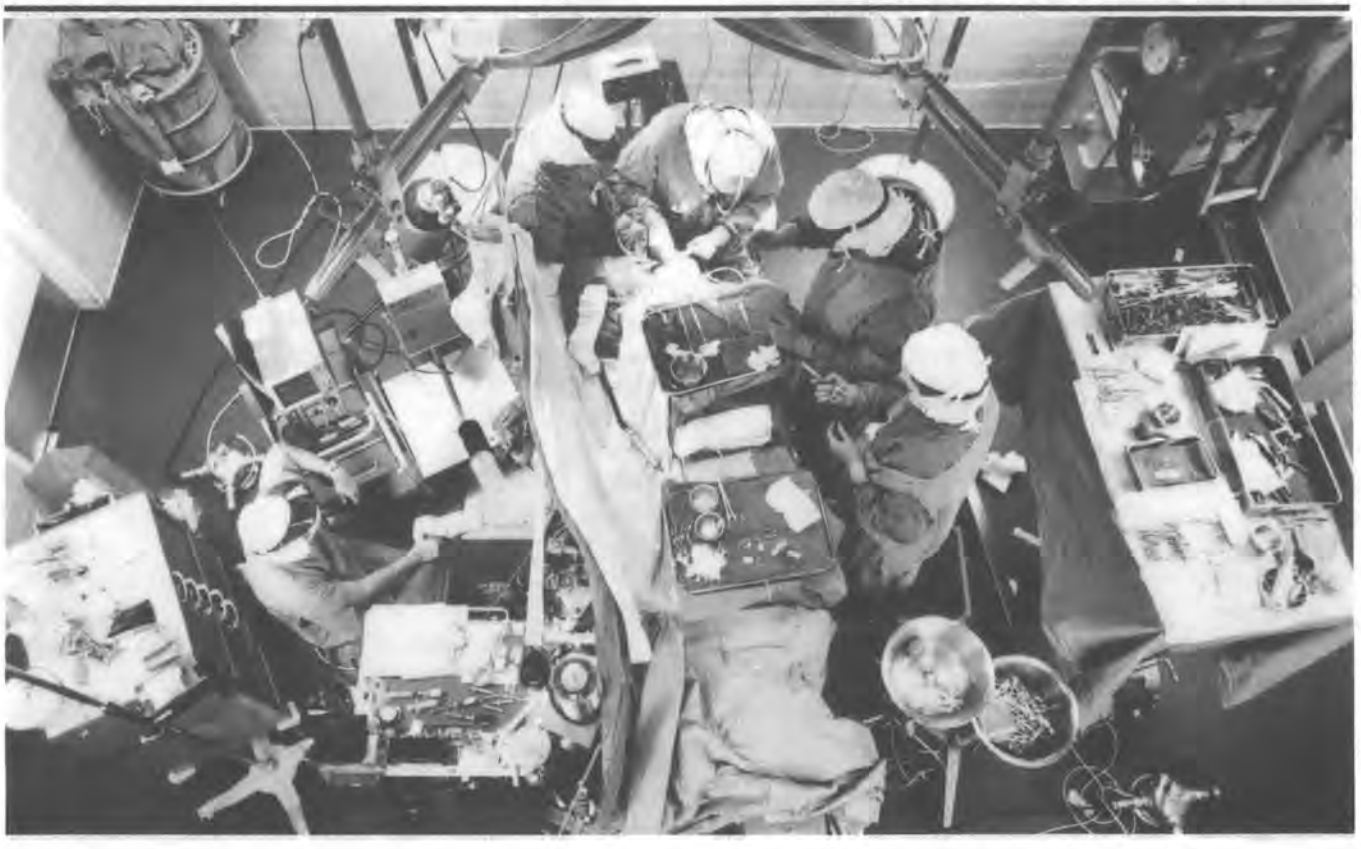


photo by Jackson Hill

Dying for Dollars

drawing by Ted Outwater

by Marc Miller

The South has long had the worst health in the nation. Stetson Kennedy documented that fact with the publication of the original *Southern Exposure* in 1947. Since the 1940s, the federal government, foundations and private enterprise have poured billions of dollars into programs intended to increase the availability of quality health care. Nevertheless, the South is still the nation's sickest region. The massive infusion of money has increased corporate profits in the health care industry far more than it has improved quality and quantity of medical service. Statistics show that the disparity between public care and private profits is still greatest in the South, as it was thirty years ago.

For example, the South has:

- the fewest number of doctors and medical professionals per capita *and* the "prime market" and home base for the largest, fastest growing medical care corporations in America;
- the highest rate of work-related disease, injury and disability *and* the least protection by low-cost group insurance plans;
- the lowest life expectancy rate in the country, *and* highest out-of-pocket per capita dollar volume of purchases from private drug companies;
- the worst availability of out-patient service and preventive-care departments *and* the highest portion of its hospital beds controlled by privately-owned, for-profit corporations;
- the least coverage by insurance, *and* the highest per capita premium paid for services received;
- the lowest proportion of elderly people receiving adequate medical care, *and* the highest portion of nursing homes controlled by private, for-profit companies;
- the lowest wages and fewest skilled employees per hospital *and* the most profitable hospital systems in the country.

Other factors make health care in the South particularly poor. Southerners, more so than other Americans, live in rural areas. Southerners suffer from dramatically higher rates of poverty. Southerners also have less money in general to spend on health care, and comparatively few of them belong to unions or other associations which provide the benefits and cost savings of employer-paid or group-rate insurance.

More significantly, however, the disparities listed above have been aggravated rather than cured by three decades of federal programs. Instead of preventing illness and injury, federal money has subsidized profit-making methods of delivering care; instead of supporting alternative programs that improve health and cut costs by competing with private medicine (as the United Mine Workers Fund did), the philosophy behind government programs has been to increase health care delivery by making it more profitable for private providers to enter the field. The result of that policy has been higher profits for corporate health providers/suppliers, inflationary costs to consumers, and only a marginal increase in the care or control people have over their health.

The Hospital Business

Large-scale federal spending began with the Hill-Burton Act of 1948, aimed at getting hospitals built in rural America. Spending skyrocketed in the 1960s with the creation of Medicare and Medicaid, and helped turn health care into a $150 billion business, second only to defense in its share of the Gross National Product. When Hill-Burton began, the government paid less than ten percent of the na-

Marc Miller is an historian working with the Institute for Southern Studies.

Lethal Statistics, 1947

from the original *Southern Exposure*, by Stetson Kennedy*

Hand in hand with undernourishment goes disease – nowhere is there a vicious circle more vicious than the misery-go-round of poverty and sickness. First poverty causes people to lose their health; then ill-health prevents them from overcoming poverty. And so the wheel of misfortune goes around and around...and when it will stop depends upon what people do about it, together.

The poor Southerner has been scrawny, puny, and ailing from way back....Mother and child have less chance of survival in the South than anywhere else in the country. In 1939 the maternity death rate (per 10,000 live births) was 56.16 in the Southeast, compared to 40.39 in the nation. Florida's rate was highest: 65.27. Similarly, the Southeast's infant death rate (per1,000 live births) was 58.6, compared to 48 for the nation. In 1937 stillbirths throughout the South ranged from a rate of 52 to 68, while the national rate was only 29.9.

When the National Youth Administration surveyed the health of its employees, it found that Southern youth exceeded the national rates for hookworm, venereal diseases, heart trouble, faulty blood pressure, and so forth.

The relatively poorer health of the relatively poorer Negroes finds expression in a life expectancy of only 45 years, as compared to 59 years for whites. In other words, to be born black in America is to be sentenced to die 14 years sooner than your white contemporaries. The Negro death rate is 32 per cent higher than the white (in 1925 it was 62.5 per cent higher); total daily sickness among Negroes is 43 per cent higher than among whites; the incidence of tuberculosis among Negroes is more than two and a half times higher than among Southern whites and five times as high as Northern whites. Moreover, the Negro maternity death rate is three times as high as the white rate, and the Negro infant mortality rate is two thirds higher than the white. Those are but a few of the hazards incurred by being born black in a white man's country.

Chief subverter of the South's health is malaria. In 1940 the Southeast's death rate from this disease (per 10,000) was .45, compared to .11 for the nation. The rates of Mississippi, Alabama, and South Carolina were highest – .80, .72, .62. Worse yet, 39 of the Southeast's counties had rates of 2 or more. On the basis of $10,000 as the value of a human life, malaria cost the South $39,500,000 in 1936 alone. More than 90 per cent of the national incidence of five or six million cases of malaria annually occurs in the South. At the minimum out-of-pocket expenditure of $40 per case, the annual cost of the South's 5,400,000 cases is $216,000,000. In addition, the disease reduces the South's industrial output approximately one third....

The Southeast's death rate from tuberculosis per 10,000 population in 1940 was 5.35, compared to the national rate of 4.99. Tennessee was high with a rate of 7.58, while 110 Southeastern counties also had rates of 7 or more.

Syphilis caused a death rate of 1.85 per 10,000 in the Southeast in 1940, while the national rate was 1.44. Florida had the highest rate, 2.65, and 76 Southeastern counties had rates of 3 or higher....

So much for the South's priorities on disease. The question is: What is being done about it? The answer is: Damned little. It is an inhuman truth that more attention has been given to the conservation of such resources as soil, water, forests, minerals, and even wild life than has been given to the preservation of human life and health.

In 1942, 204 of the Southeast's counties – nearly a third of the total – neither had full-time public-health departments nor were included in consolidated full-time health districts. Georgia was worst-off in this respect, with two thirds of its counties lacking full-time health service; and more than half of Florida's counties were likewise deficient. Even of those Southeastern counties which had full-time health service, more than half had 2 or less health-service employees for every 10,000 persons in the population; while only 6 per cent had more than 4 employees per 10,000 population. Total receipts for public-health services in 83 per cent of the counties were less than 71 cents per capita, and more than 40 per cent of the counties took in less than 40 cents per capita per year. Altogether, public-health expenditures in the region in 1941 amounted to only 7 percent of the national total – to provide for 14 percent of the country's people.

"Obviously most of the health departments in the region are without adequate personnel to carry on an effective health program," concludes the Planning *Report*. The need is greatest in the thinly populated rural counties, and the most immediately available solution for them would seem to be consolidation into health districts.

Another aspect of the South's lack of medical service is the region's wholly inadequate number of physicians. With its 14 percent of the nation's people, the Southeast in 1940 had but 9 percent of the nation's physicians to serve them. In 80 percent of the region's counties there was but one physician for every 1,112 people.

Still another index to the region's lack of health facilities is the fact that in 1939 it had but 11.5 per cent of the nation's hospitals to accommodate its 14 percent of the nation's people. Even more indicative of the inadequacy of the region's hospital facilities is the fact that it had only 5.57 hospital beds for every 1,000 people, while the nation had 9.74. Furthermore, 41 percent of the region's counties had less than 3 beds for every 1,000 people, while less than 1 percent of the counties had as many as 5 beds per 1,000 persons.

To add tragedy to tragedy, even these hospital beds are not fully occupied – not because Southerners shouldn't be in them, but because they can't pay the price. In part this is due to the fact that a greater proportion of the Southeast's hospitals are under private control than are those throughout America. More than half of the region's counties had no general hospitals in 1941. □

*Excerpted from *Southern Exposure*, a 1947 muckraking account of the South's problems.

tion's health care bill; today, it pays a fourth of the bill. As a result, corporations which once contented themselves with profiting on poor health by selling drugs, insurance or medical supplies have now expanded their business into the actual delivery of health care itself. And they have been particularly interested in the $60 billion which gets spent annually in the nation's 7,000 hospitals.

Currently, Americans choose among several types of general purpose hospitals. Over half are privately-owned institutions run on a not-for-profit basis; another 35% are operated by governments. But a growing number — 13%— are owned by investors in search of profits. The South has a disproportionate share of these so-called proprietary hospitals: of its 2,000 hospitals employing almost a half million workers, one-third are private, not-for-profit, 45% are government owned, and 21% are proprietary.

The relatively higher proportion of government-owned hospitals in the South has helped make the region the industry's number one target. Historically, Southern lawmakers have favored private control over government control; they are easily convinced by the leading argument in favor of proprietary hospitals: as cost-conscious, profit-making businesses, they keep the costs of health service down. Unfortunately, keeping the costs down can also mean — as it has with other public services in the South — sharp cutbacks in the quality of care.

In fact, the cost-cutting, business-minded approach epitomized by the investor-owned proprietaries characterizes all hospital care in the South. Most obviously, hospitals in the region spend less on each patient, despite the fact that a higher proportion of Southerners suffer from disabling illnesses or accidents, relative to the nation as a whole. Southern hospitals also save money by hiring fewer workers per patient and paying the workers the lowest wages in the nation: about $7,500 per year, a third below what hospital workers receive in the Northeast and Pacific states, and $2,000 below the average annual wage for manufacturing workers in the South. Contrary to many reports, the low wages of hospital workers have only kept pace with inflation, while non-payroll expenses (and costs to consumers) have increased much faster. The rising cost of hospital care has been due primarily to unnecessary expansion and expensive equipment purchases, not to increased wages for hospital workers.

Hospitals in the South also save by relying heavily upon those workers who are unskilled, hence the cheapest to employ. Thus, they employ fewer doctors and registered nurses, but more licensed practical nurses. Rural America as a whole is underserved in almost every category except nurse's aides (including orderlies and attendants) and specialties like veterinarians and lay midwives. Highly trained professionals are not necessarily *better* health care providers, but in our society their presence does indicate a commitment to *more* health care.

Better health care does result from aggressive outpatient programs in hospitals. These programs are especially important to poor people who can not afford private physicians. But with large numbers of unoccupied hospital beds, administrators prefer patients to stay in the hospital overnight where profits are high. Out-

HEALTH STATISTICS

	United States	South
Population-to-physician ratio 1974[1]	766	972
Full-time nurses in hospitals per 1,000 beds, 1973[1]		
RNs	262	227
LPNs	139	156
Full-time nurses in nursing homes per 1,000 beds, 1972[1]		
RNs	31	26
LPNs	42	51
Outpatient visits per 1,000 population, 1973[1]	1,125	976
Unable to carry on major activity due to chronic disability, 1969-'71[1]	2.9%	3.9%
Infant death rate per 1,000 live births, 1976[1]	15.1	17.4
Work injuries per 1,000 people per year, 1969-'70[3]	4.0	4.2 urban; 4.3 nonurban
Home injuries per 1,000 people per year, 1969-'70[3]	10.4	9.1 urban; 11.5 nonurban
Prescription drug purchases per person, 1973[2]	$23.80	$26.70 (whole South) $29.10 (rural South)
Percent population under 65 with health insurance covering hospital expenses, 1975[1]	86.4%	79.2%
covered for regular medical expenses, 1975[1]	79.5%	63.1%

SOURCE: 1. Statistics compiled and supplied by Region IV office, United States Department of Health, Education and Welfare, Public Health Service, Atlanta.
2. USDHEW, PHS, Health Resources Administration *Vital and Health Statistics: Data from the National Health Survey.*
3. USDHEW *Health Characteristics, by Geographic Region, Large Metropolitan Areas, and Other Places of Residence, United States, 1969-70.*

patient departments are among the first programs cut by money-conscious administrators.

The dramatic influx of money through Medicare and Medicaid has directly encouraged profiting from patient care.

Unfortunately, treating only the most profitable diseases is entirely legal. Sometimes. Under the 1948 Hill-Burton Act, the federal government has spent $3.25 billion for the construction of hospitals in underserved rural areas. In return, Hill-Burton hospitals must, by law, provide a certain amount of free service to people unable to pay. But in 1974, the Southern Regional Council documented the systematic denial of free health care in these hospitals. Many hospitals simply ignore the requirement to advertise clearly the availability of free health care. In other cases, people who might be eligible are harassed for payment of their bills. Those who do inquire about the eligibility for free care are often told the hospital can not give an answer in advance of treatment; fearing bills, many simply stay away. Finally, and in direct violation of the Hill-Burton Act, some hospitals write off bad debts and charges beyond the "reasonable cost" reimbursements allowed under Medicaid and Medicare as "free service" to the poor.

Of course, proprietary hospitals have no legal obligation to provide free care. In fact, much of their increased income derives simply from increased harassment of patients to pay bills. Proprietaries combine all the cost-conscious practices of other hospital administrators with none of the imperatives to keep their doors open to all people. They can simply refuse to serve any patient whose payment is not guaranteed in cash or by some third-party payer, such as the federal government or an insurance company. The dramatic influx of federal health money through Medicare and Medicaid has directly encouraged this policy of profiting from the care of every patient, regardless of their ability to pay. It has likewise encouraged the rise of a new breed of multi-million dollar corporations, the hospital chain, whose stocks have soared on Wall Street despite the economy's stagflation.

The biggest chains (see chart) all do a large portion of their business in the Sunbelt. Their approach to hospital care is perhaps best symbolized by the fact that hotel chains like Hyatt and Ramada Inn hold significant shares of the industry. Hilton Hotels, a subsidiary of TWA, recently attempted to enter the business by offering to buy American Medicorp for over $100 million, but was outbid by Humana, the nation's second-largest proprietary chain. While the best of the bunch try to avoid the reputation of being "Holiday Inns with patients," they do follow the basic dictates of trade — for maximum occupancy, efficient use of resources, standardized service, computerized billing, low wages, etc.

Hospital Corporation of America (HCA), based in Nashville, heads the field with a growth rate which would be impressive for any other industry, but which is typical among proprietary hospital chains. Founded in 1960, and thus the oldest of the majors, HCA began its spectacular rise by buying seventeen other companies during 1968-69. As of September, 1977, HCA owned 72 hospitals (11% of this nation's investor-owned hospitals) and managed another 23 (12% of the hospital management market). In 1970, the entire industry had combined revenues of $500 million; in 1976, HCA alone grossed $506 million, 36% of that from Medicare and Medicaid. Its annual income has been increasing 21% each year.

Because proprietaries still account for only a small portion of all hospitals, HCA has many institutions left to pick from; it favors those in the suburbs of the Sunbelt almost exclusively. But HCA's success does not actually reflect an existing need for its services. Its hospitals have an average occupancy rate of 67% compared with 74.5% for all general hospitals; the ideal is 85%. In fact, most HCA hospitals simply replace older facilities with operations based on new cost-cutting techniques, including much lower costs for labor. Only one HCA hospital has a union.

While the policies of proprietary hospitals often point up the inequities and failures of health care, they do make money for investors. Actual ownership by for-profit companies continues to account for only a fraction of all hospitals, but the cost-conscious philosophy which they espouse is increasingly attractive to trustees of other hospitals, as well as to local governments. The result has been the creation of a second avenue by which profit-minded corporations can move in on the multi-billion dollar hospital market: the hospital management company.

The largest of these firms are the proprietary hospital chains themselves, like HCA and American Medicorp. Hospital Affiliates, Inc. (HAI), also based in Nashville, boasts a growth rate twice that of its parent company, INA, the

GENERAL HOSPITALS BY TYPE OF OWNERSHIP

State and County	Total Number of Hospitals	State and Local Government	Federal Government	Proprietary	Non-Profit
United States	6458	29%	6%	13%	53%
Alabama	138	57%	5%	15%	22%
Arkansas	101	48%	4%	16%	33%
Florida	214	34%	7%	20%	39%
Georgia	178	66%	6%	15%	14%
Kentucky	116	28%	4%	10%	58%
Louisiana	151	44%	5%	30%	21%
Mississippi	126	66%	4%	8%	22%
North Carolina	143	30%	6%	5%	59%
South Carolina	84	45%	8%	8%	38%
Tennessee	149	40%	3%	32%	25%
Texas	531	33%	5%	32%	30%
Virginia	110	7%	10%	20%	63%
West Virginia	80	26%	8%	24%	43%
South	2121	40%	5%	21%	34%

$2.9 billion insurance corporation. Probably the largest management firm, HAI operates 66 hospitals in addition to the 44 it owns outright; figures for both categories rose 50% in two years. Like proprietaries, hospital management by contract arose during the early stages of the Medicare/Medicaid era; Hospital Affiliates is only ten years old, and its 10,000-plus employees bring in over $100 million each year.

Make no mistake, hospitals do not hire management firms to improve health care. The primary purpose is to ensure the financial growth of the institution. The fee paid the managers is contingent not upon quality of service, nor even upon increased efficiency, but on a percentage of growth in the hospital's revenues. The more money a hospital brings in (i.e., the bigger it grows), regardless of quality or even profitability, the more the management firm gets paid. Expansion is the key to profit, even for hospitals which are already too large and centralized.

Insuring Profits

If the private management companies can not be expected to hold down the cost of your medical care, neither can the insurance companies. Although common sense suggests that insurance companies would try to keep hospital bills down in order to maximize their profits, it just doesn't work that way. Government regulation of the insurance industry, like federal regulation of utilities, is designed to guarantee the investor-owned companies a "reasonable" rate of profit. Instead of keeping costs down, regulation allows the insurance companies to pass increased medical costs on to consumers without suffering any decrease in profit. Insurers only need to make sure the costs of their policies remain affordable for the consumer. One solution the industry favors is national health insurance that subsidizes coverage of all Americans by private companies. Another, more immediate plan, euphemistically called "co-payment," allows the companies to pay a smaller portion of the hospital bill, leaving the consumer to pay the balance directly.

Some insurance companies have found another way around higher hospital bills. They have entered the business themselves; when they pay the providers, they pay themselves.

HCA HOSPITALS, 1976

"Health Care Is A Business With A Healthy Future"

HOSPITAL CORPORATION OF AMERICA

INA has taken the lead in this questionable practice. For several years, INA has owned a portion of AID, Inc., a proprietary chain controlling 5% of the investor-owned hospital market. In 1976, INA increased its share of AID from 64% to 91%, "reflecting INA's belief that the health care field will continue to expand profitably." Indeed, over the last five years, AID's profits increased 20% annually. Undoubtedly, the rapid growth of AID encouraged the parent company to buy Hospital Affiliates International in 1977.

The insurance industry's concern about getting their profits first and worrying about high costs later has been doubly hard on policy holders in the South. Southerners already get shortchanged on the protection they receive for the money they contribute in premium payments, largely because they tend to be covered by individual, instead of group, policies. More of their money is thus eaten up by the insurers' administrative overhead (e.g., processing 100 individual premium payments is much more expensive than processing one group payment for 100 people). Nationally, half the people with health insurance purchase the more expensive private plan; but in the South, two-thirds use private plans. A primary cause of this difference is the lack of unions in the South to force employers to provide group insurance for their workers.

The South also receives fewer benefits from Medicare and Medicaid. Rural residents are especially hurt. Last year, city dwellers received an average of $123 from Medicaid, while those outside the city got only $78 per person. Nearly all the Southern states rank in the bottom third of reimbursement rates, despite the region's obvious health and poverty problems.

Blue Cross/Blue Shield programs return more money to Southerners than the private companies, but they still respond to doctors and hospitals, not to patients. For example, Blue Shield plans, which cover about 40% of the population, account for one-fourth of all money paid to doctors; Federal Trade Commission investigations have shown that most plans are controlled not by health consumers, but by medical societies and local

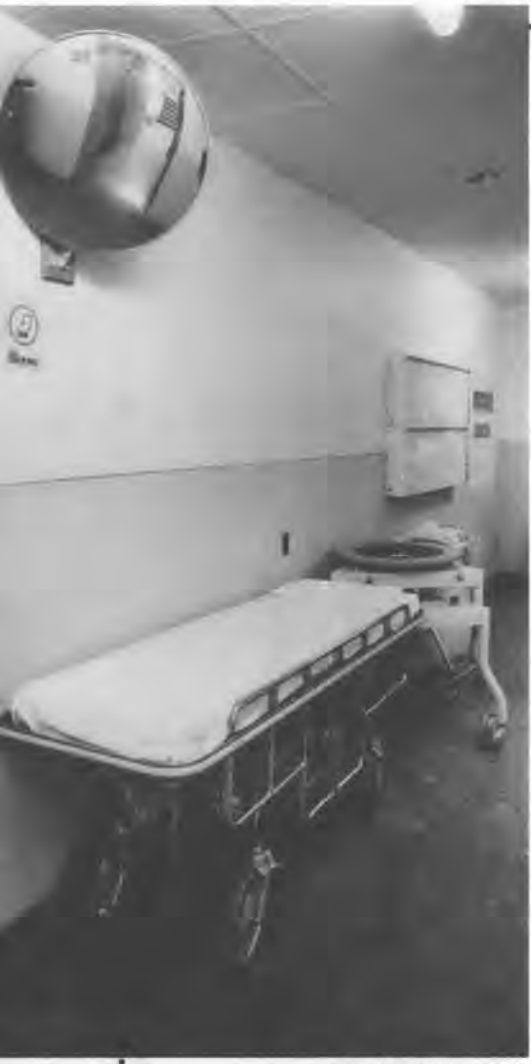


photo by Jackson Hill

Keeping the Public Out

In 1974, Congress enacted the National Health Planning and Resources Act directed at clearing up the institutional and bureaucratic nightmare that followed the creation of Medicaid and Medicare in the 1960s. Under the new act, health planning decisions became the responsibility of regional Health Systems Agencies (HSAs) rather than allowing the uncoordinated expansion of the health care system to continue unchecked.

Last year, the Southern Regional Council surveyed the operations of twenty-eight Southern HSAs (about half the total) and published its findings in *Placebo or Cure? State and Local Health Planning Agencies in the South*. The SRC survey found that, despite their newness, the HSAs "are dominated by vested medical interests, and have failed to promote comprehensive health planning and stem soaring medical costs.... The HSAs are simply not effective health planning agents."

The SRC report focuses on the crucial innovation of the Health Planning Act to survive the onslaught of lobbyists from the American Hospital Association, the National Association of Counties and the National Governors' Conference. Despite the lobbies, the final act required that consumers —rather than providers— be the majority on HSA boards and that each board contain full representation by women, minority groups and low-income people. Consumer control would, in theory, challenge the power of professional health care providers who have no interest in keeping prices down. The SRC study concludes that "hospital administrators and medical doctors are over-represented on most HSA boards. They enhance their power by selecting sympathetic HSA directors and staff who dilute the influence not only of consumer representatives, but of health providers other than medical directors and hospital administrators....Women, minority groups, and the poor were often found to be under-represented or not represented at all."

The SRC report points out:

- One of the low-income members of the Florida Gulf Health Systems Agency *owns* low-income housing.
- Of the eight low-income members of the Mid-Louisiana HSA, "four are teachers, one is a retired city councilman, another is a construction worker, another is a bus driver, and one is executive secretary of the Chamber of Commerce."
- The West Arkansas HSA says only people familiar with health care problems could be effective on its board. Of its thirty members, only five are women.
- Members of the North Alabama HSA were nominated almost exclusively by health care providers who had a decided bias against any government involvement in health planning. One board member said, "What do [consumers] know about health care needs."
- Texas lags far behind the rest of the South in developing any HSAs — let alone effective HSAs — due to the opposition of Governor Dolph Briscoe.
- With one exception — the Mississippi HSA in Jackson — no HSA in the South is controlled by its consumer members.
- A Charlotte, NC, lawyer nominated for the Southern Piedmont HSA stated, "Every good American should oppose this legislation." A former board chairman concurred: "The people on the board of Southern Piedmont Health Systems Agency have the same interests as you or I, preserving a voluntary, private health system."
- The US Department of Health, Education and Welfare has exhibited little interest in enforcing provisions of the Health Planning Act mandating public accountability and consumer representation. □

Placebo or Cure? State and Local Health Planning Agencies in the South is available for $5 ($4 each for ten or more) from the Southern Regional Council, 75 Marietta Street, NW, Atlanta, Ga. 30303, (404)522-8764.

physician associations. At Congressional hearings, Rep. Albert Gore of Tennessee noted that many members of Blue Shield boards also serve on boards of major institutions which hold Blue Shield funds. "These persons," said Gore, "also have a direct interest in seeing that these financial institutions make a profit."

Health vs. Wealth

The South suffers further at the hands of the true giants of the medical industry – the pharmaceutical companies. In 1975, consumers spent $10 billion on drugs directly and billions more indirectly through hospitals. Drug companies, unlike proprietary hospitals, have been around a long time, but their revenues took a sharp upswing with the discovery of antibiotics in the 1940s, and birth control pills in the '60s.

The continuously expanding market has produced a relatively calm, albeit still quite profitable industry dominated by giant corporations. Forthcoming federal legislation may soon limit drug prices, but will also extend Medicare/Medicaid coverage of drug purchases by consumers.

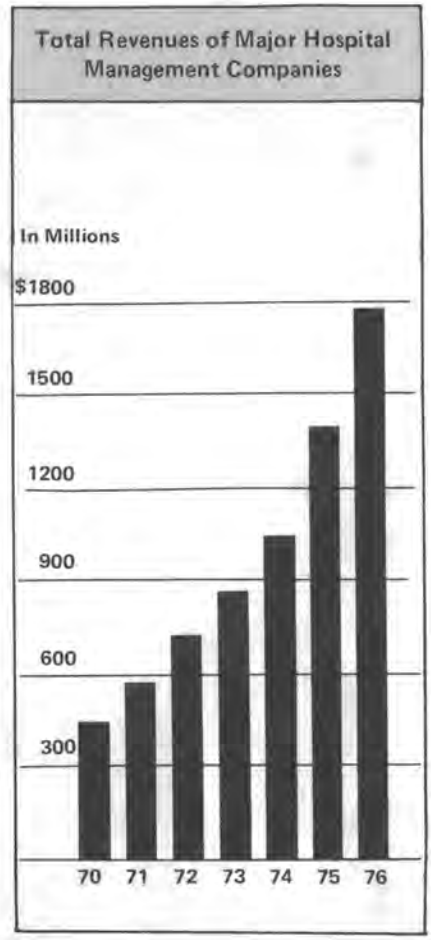
The average American spent $23.80 of pocket money on prescriptions in 1973; Southerners spent $26.70; rural Southerners spent $29.10. Southerners were also more likely to receive no reimbursement for these purchases from federal programs. While each purchase cost less, Southerners made far more individual purchases in the course of a year.

The health industry obviously extends far beyond hospitals, insurance and drug companies. With quick profits to be made in the construction of hospital facilities, companies devoted solely to this purpose now earn $4.5 billion a year. For a set fee, they will build a hospital; other companies locate financial partners on investments. Typical of the new breed of health care contractors is Elmo R. Zumwalt, former chief of US naval operations and unsuccessful candidate for the US Senate from Virginia. Zumwalt entered the medical field in October, 1977, as president of American Medical Building, Inc., a hospital construction company. His Washington contacts will more than make up for his ignorance of health care delivery.

Nursing homes account for another $10 billion of our health care money each year. In fact, nursing homes are now the fastest growing part of the health industry with a 53% increase in revenues between 1972 and 1975. Like hospitals, two types of nursing homes co-exist, for profit and non-profit. The South has once again been the favored location of the proprietary institution. But unlike proprietary hospitals, which have a moderately respectable public image, the nursing-home-for-profit has been one of the scandals of the decade. Despite their rapid growth in revenue, however, nursing homes show a relatively low rate of profit (about 5% on invested capital), and major corporations are starting to move from nursing homes to hospitals in pursuit of a higher rate of profit (6.3%).

Health Empires Without Health

Americans spend an ungodly amount of money on health. The hundreds of billions of dollars must end up in someone's pockets. Financial empires exist on our poor health. Undeniably, some health problems have lessened in the three decades since Stetson Kennedy pinpointed the South as the worst region, but the South still lags. Friendliness to private enterprise, the high degree of poverty, the large rural population, and the shortage of unions and consumer



CORPORATE HEALTH

	1977 sales (in thous.)	percent increase from 1976	1977 profits (in thous.)	percent increase from 1976
DRUGS & HOSPITAL SUPPLY				
American Home Products	$2867.9	9%	$306.2	10%
American Hospital Supply	1488.2	11	77.9	18
Bristol-Myers	2191.4	10	174.3	11
Johnson & Johnson	2914.1	16	247.3	20
Eli Lilly	1518.0	12	218.7	8
Merck	1724.4	10	277.5	9
Pfizer	2031.9	8	175.4	10
Warner-Lambert	2542.7	8	187.6	18
HOSPITALS				
American Medical International	$356.8	17%	$ 14.4	53%
American Medicorp*	346.0	19	15.0	21
Hospital Corporation of America	627.4	24	33.7	23
Humana	391.3	25	13.0	41
National Medical Enterprises	180.5	36	7.7	28

Source: *Business Week*, March 20, 1978 (except where noted)
*9 months ending Sept. 30, 1977 (Source: Standard & Poor's)

organizations all contribute to keeping the South at the bottom.

The primary cause of inflation in health costs has been the failure of the federal government to challenge private control of health care delivery.

The prime cause for the inflation of health costs has been, not the vast sums spent by Washington, but the design of the spending programs. At no point have federal programs been willing to challenge or compete with private control of the delivery of health care. Regulations now being pushed by advocates of private control, led by Senator Herman Talmadge of Georgia, would begin to control costs but might threaten public and non-profit institutions (see box). Similarly, doctors have been almost free to charge whatever they liked knowing their services were necessary, their rates beyond effective public control and their monopoly secure. In other words, the providers who profit control the health care system rather than the consumers who pay the bills. The goal of the providers is profit; the goal of the consumers is health. The arrangement encourages inflation and discourages quality care.

Fortune Magazine

The pursuit of profits in the health care industry has deeper effects, effects felt most strongly in the South. Our health care system functions mainly to take care of problems after they occur rather than attempt to prevent their occurrence. This is best illustrated by the high rate of work accidents in the South and the prevalence of work-related diseases such as black lung and brown lung. Southern states have been unwilling to enact or enforce laws to effectively protect the health and safety of workers.

The problem has become severe enough to be too costly to employers as well as workers. A few corporations have instituted health insurance programs designed to prevent illness, both to lessen demands for the protection offered by unions and to ensure a healthier work force. Some Southern politicians have even introduced federal brown lung legislation, to shift the responsibility for compensation to the national treasury, e.g., the taxpayer. Southern states still largely refuse to insist that corporations provide health insurance or healthy working conditions for fear of implying that workers have any rights beyond those insisted upon by Washington.

The failure to control corporations has implications for health extending far beyond the workplace. The primary cause of much disease is poverty. Poverty means not only less ability to purchase care, but also less money for adequate food, less money for adequate housing, less education stressing the importance of proper health care. To

Why Investors in the Proprietary Hospitals

"Why Investors... Love Herman Talmadge." That's not an original title. *Fortune*, "the magazine for business," used it in December, 1977, without intending irony or criticism. Specifically, *Fortune's* article described the delight with which proprietary hospitals view Talmadge's Medicare and Medicaid Administrative and Reimbursement Reform Act. That unwieldy title avoids the announced purpose: to control the rapid rise of hospital costs. His bill is one of several now being considered by Congress; Talmadge's and another proposed by President Carter share the limelight.

What makes the debate crucial is the extremely high inflation in the health industry. Hospital expenses for the nation increase at over one million dollars every *hour*, or at a rate two and a half times faster than the rest of the country's inflation. A day in the hospital cost $15.62 in 1950; $175.08 in 1976. Some form of cost containment bill is almost inevitable this year.

Carter's bill sets immediate limits on the increase in hospital revenue next year to nine percent over this year's revenue. Other features of his plan encourage use of outpatient services rather than overnight admissions, exempt pay increases for low-paid hospital workers from the nine percent figure, and limit major expenditures for expansion and expensive equipment to under $2.5 billion next year. The Department of Health, Education and Welfare regards the nine percent cap and other provisions as necessary predecessors to a workable National Health Insurance somewhere in the future. The proprietaries do not like Carter's plan. In the words of their lobbyist, "[HEW Secretary Califano's] gratuitous attack upon the free enterprise system cannot disguise the bankruptcy of the HEW cost containment proposal."

While Carter's plan claims to punish hospitals for high costs, the Talmadge plan – co-sponsored by Russell Long and a number of less powerful senators – claims to control cost by rewarding

improve health would require challenging the causes of poverty.

The inequitable distribution of wealth has further social results that adversely affect health. Up to 90% of cancers – the prima donna disease of industrialized nations – result from the chemicals in the air and water. Most cancers could be *prevented* by cleaning up the environment: that is, by controlling the corporations that do the polluting. Yet the costly research focuses on finding cures for the remaining 10% of cancer associated with viruses. The $2.75 billion dollars going to medical research each year may not have cured cancer, but it has created quite a few empires in universities, research hospitals and private laboratories across the nation.

Ultimately, consumers pay all the costs of health care – in tax money, in insurance premiums, in sickness. Solutions to the health care dilemma will come when health decisions are made, not by corporation executives on the basis of profits, but by health workers and consumers on the basis of our need. □

photo by Jackson Hill

Love Herman Talmadge

efficient hospitals. Although Talmadge insists his bill would encourage lower hospital charges, it appears just as likely to encourage overcharges. If a hospital charged less than the going rate for service, it would share the savings with government reimbursement agencies. But high charges would be reimbursed up to twenty percent over the going rate. The going rate is accepted as a reasonable standard, a dubious proposition. Although announced as a cost-containment concept, Talmadge's proposal sets significantly *higher* limits on profits than presently allowed in Medicare/Medicaid reimbursements. Lastly, unlike the Carter proposal which would take effect immediately, Talmadge's controls would not become fully effective until 1981. Costs would continue to soar until then.

The American Hospital Association (AHA) prefers Talmadge's bill because it sets no limits on revenue increases (nine percent in Carter's). The Federation of American Hospitals (FAH), the industry association for proprietary hospitals, prefers Talmadge's Bill because it sets no limits on expansion ($2.5 billion in Carter's.) With so much industry support, the Talmadge Plan might be in danger of being unacceptable to liberals, except that the AHA and the FAH – with the AMA – have proposed a third plan. The industry idea makes all cost controls voluntary, relying on publicity focused on those hospitals which exceed the voluntary standards as the only punishment. Besides its obvious similarity to the non-control that has already given us such high prices for hospital care, the industry plan probably violates antitrust law because it suggests hospitals agree among themselves on what to charge. The FHA-AHA-AMA plan has no hope of passing, but it may nudge congressional debate several steps to the right.

Some program will pass this year, probably an amalgam of Carter's and Talmadge's plans. Although they have been compared to carrot-and-stick, the two camps see themselves as almost compatible. Talmadge initially gave tepid support to the general approach of the Carter proposal, while the administration stresses it supports the Talmadge plan in the long run with the nine percent cap needed immediately.

Meanwhile, Talmadge holds the key to any legislation as Chairman of the Senate Finance Subcommittee on Health. The proprietaries *like* his bill, but they *love* his pace: Carter proposed the cap last April, but the Senate version never reached the floor as Talmadge delayed revealing his plan for several months and then delayed hearings.

As the debate drags on, the publicity around the need for controlling expenses enhances the value of hospital management stocks. And in spite of their furious words, the proprietary hospitals are not extremely worried. As the FAH's Michael Bromberg says, "Even with the sharpest legislation, I'm not afraid of what's coming. The nonprofit hospital is our umbrella. They'd have to go bankrupt before we'd be hurt." □

An Alternative?
Health Maintenance Organizations

drawing by Ted Outwater

While American health care focuses on cure, a turn-of-the-century concept of medical care designed to prevent illness has come into prominence in recent years. Stimulated by rising health care expenses and an unhealthy workforce, corporations and the federal government have both been examining the potentials of health maintenance organization (HMOs). Even more importantly, many people view the HMO as the best vehicle for providing good health care in rural areas.

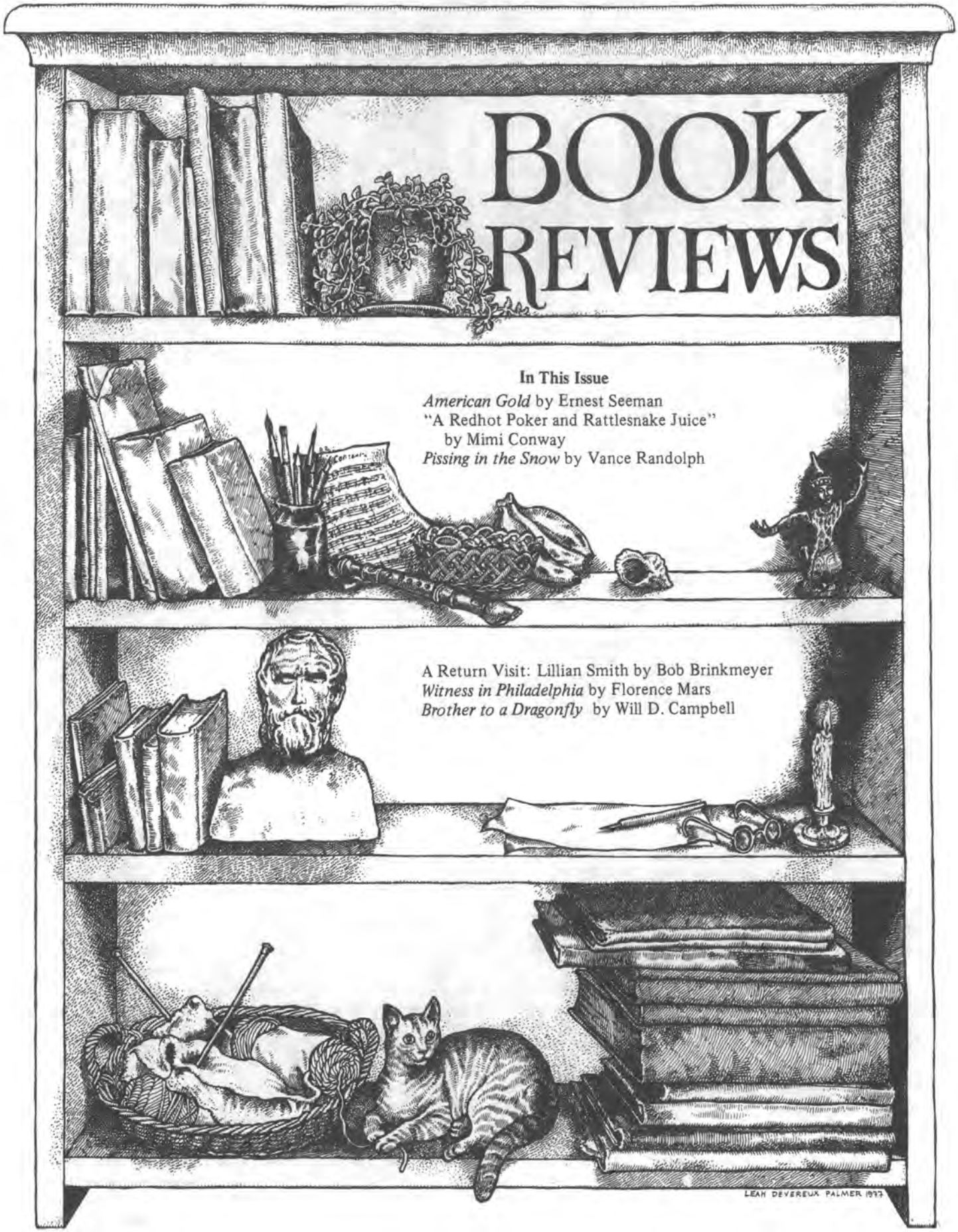
On the surface, HMOs resemble insurance programs. Members pay set fees in advance for medical care as a whole. The similarity soon ends, however. HMOs provide care, while insurance companies simply pay the bills. Because the income of an HMO is limited by the fees it collects monthly, the HMO must – as a business – strive to keep its expenses down. The major avenue for accomplishing this is to provide care before illness appears. Members of an HMO receive, in addition to insurance coverage for hospitalization, the availability of a doctor and related staff for regular check-ups and tests. By keeping members healthy, HMOs cut the rate of hospitalization – with its accompanying higher costs – in half. And because fees are collected in advance, rural HMOs can attract medical professionals by guaranteeing their income.

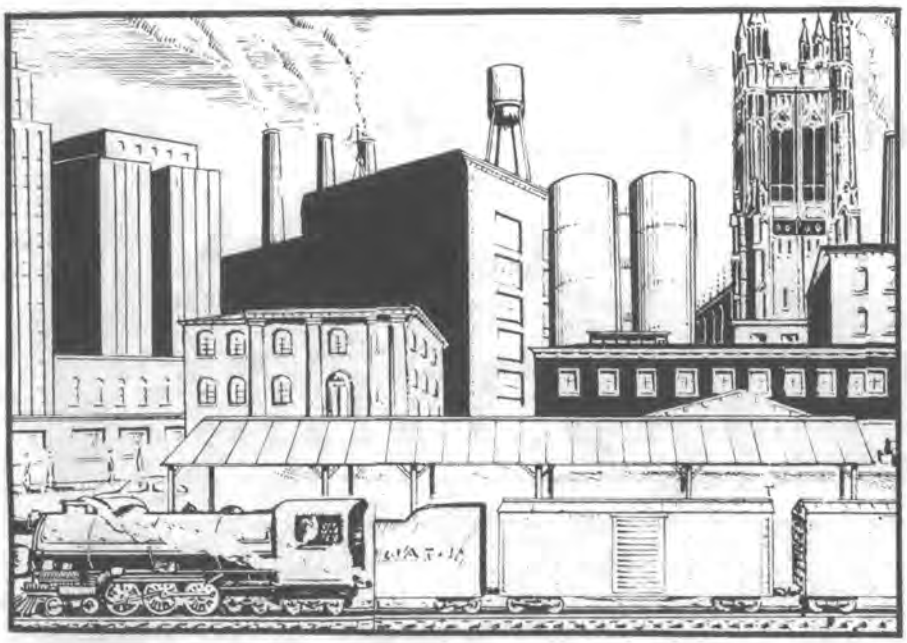
Despite its obvious health benefits and a 1973 federal law supporting HMOs, prepaid, preventive health care bypasses the South for the same reasons the South has always been shortchanged on health. The effectiveness – indeed, the life – of an HMO depends largely on the resources available within a community. Many rural areas can not enroll enough members in an HMO to maintain a clinic and pay the doctors enough money to compete with the income he or she could get in a city by charging each patient for each visit (the fee-for-service system.) Moreover, rural areas less often have the organizations which could help create and operate an HMO. Lastly, medical professionals often prefer urban areas for reasons beyond the financial rewards to be found there.

The one large-scale, successful HMO in the South is the exception that proves the rule. R.J. Reynolds, the nation's leading cigarette manufacturer, began an HMO in 1976 for its workers. But the Reynolds HMO serves a major city, Winston-Salem, not rural North Carolina. Although severely underserved, Winston-Salem already does have proportionately more medical services than most North Carolina counties. Winston-Salem has an HMO because it has the prerequisites that rural areas lack. First, it has people: 10,000 people joined the Reynolds HMO in its first year; 30,000 will soon belong. Second, Winston-Salem has a powerful corporation willing to organize an HMO and use its influence to overcome doctors' traditional opposition to the HMO's threat to their profits under fee-for-service. In fact, the Reynolds HMO grew out of the corporation president's inability to find a private doctor when he moved to Winston-Salem. Unlike poor and rural people, he could call on the resources of a multinational corporation to solve his problem. Third, Reynolds' HMO could attract doctors partially because it is located in a city and because the HMO is big enough to finance a well-equipped clinic.

But, R.J. Reynolds is the exception in the South. Most corporations do not offer HMOs for employees just as they do not offer health insurance. Fringe benefits, such as medical insurance or an HMO, tend to reflect unionization and pay scales. Just as Southern businessmen refuse to recognize unions, and pay the lowest wages, so they resist offering HMOs. The federal HMO Act does little to push companies to provide health care; it obligates those large employers who *do* provide health insurance to offer HMO as an option. More important, the law says nothing about deducting HMO payments from paychecks: the check-off. Just as check-offs for union dues guarantee the economic strength of unions, so check-offs for an HMO guarantee its viability. Southern employers oppose the check-off just as they oppose any compulsory benefits as an infringement of their absolute power. Since the act said nothing about the check-off, Duke Power challenged the regulation requiring it in court in 1976 and won. As the director of a small, non-corporation HMO in Greenville, South Carolina, put it, "The people who write HMO regulations must not have heard about places like Greenville."

HMOs are not without their dangers. With a fixed income, an HMO must limit expenses and – without consumer control – could be liable to the same business-minded limitations as a proprietary hospital. On the other hand, because they hold down costs and have a steady income, HMOs may be viewed by business as another investment: American Medical International took the first small steps in this direction by purchasing two HMOs in 1977. (It began by introducing measures to control high expenses.) And, of course, corporations like R.J. Reynolds do not create an HMO out of sheer generosity. The Reynolds HMO means 1) workers are out sick less often; 2) the company has another argument against unionization; and 3) the company reaps the profits from health care rather than the expenses. While Reynolds boasts about its HMO, the company refuses to provide the evidence of its financial success. "We don't want our people to think we're profiteering on their health." □


BOOK
REVIEWS
In This Issue
American Gold by Ernest Seeman
"A Redhot Poker and Rattlesnake Juice"
by Mimi Conway
Pissing in the Snow by Vance Randolph
A Return Visit: Lillian Smith by Bob Brinkmeyer
Witness in Philadelphia by Florence Mars
Brother to a Dragonfly by Will D. Campbell
LEAH DEVEREUX PALMER 1977



American Gold

By Ernest Seeman, Dial Press, 1978. 380 pp. $8.95.

By Chris Mayfield and Bob Brinkmeyer

On the eve of its publication, Ernest Seeman's *American Gold* is being hailed as a newly discovered 1930s classic, a fiery, quasi-historical expose of the tobacco-rich Dukes and their impact on a sleepy Carolina village. Some go further, claiming that this book, with its wild humor, inventive language and vivid portrayal of the rise of American industrialism, is a great American novel – in fact, *the* great American novel, the one we've all been waiting for.

There can be no question of the importance of *American Gold* as a devastating and often wildly comic piece of political satire, which would undoubtedly have rocked the country had it been published in the 1930s and '40s. Heads will roll, ears will burn even today. Anyone interested in the roots of our mechanized society (and particularly any resident of Durham, NC, Seeman's "Warham") will learn a lot about the blood spilled in the construction of the Duke empire, and the sharp stratifications of wealth and poverty which today still divide this city, as they divide countless other industrial towns across this nation.

Chris Mayfield is a free lance writer in Durham, N.C. Bob Brinkmeyer teaches English at North Carolina Central University.

Politics aside, though, how does *American Gold* stand up when it is judged on its literary merits? Well, it's certainly good – Seeman is undeniably talented, and his material is rich and original. But the book as a whole has a jerky, uncompleted quality.

There is, however, much to praise. This is not just a fictionalized account of early Durham; we are shown here what can happen to any community suddenly thrust from a passing era into the next age. The story is told with great liveliness and color. Like a wild hillbilly James Joyce, Seeman stretches and condenses and recreates the English language. Here he is, describing T.P. Warham (J.B. Duke) as he rounds up cash for his advertising ventures:

In these emergencies they would coincomb the town for metal. T.P., dressed in his Sunday best, with a flower in his buttonhole, a big cigar in his mouth and lots of them in his pockets for give-away purposes, and a bottle of Old Hunk's XXX Superior Tennessee Corn on his hip, would sally forth in person as briggety and full of brass guts as a brass monkey to round up the necessary true spondulix.

The place names with which Seeman constructs his town are nothing short of wonderful; who can resist Swelldoodle Hill, the Ruby Mill Bottom, and Mud and Morning Glory alleys? And much of the novel is downright sidesplittingly hilarious – for instance, the Wah Sing chapter, one Chinaman's view of Durham in the 1880s.

In addition, *American Gold* contains several passages of profound, almost poetic beauty, in which Seeman makes us feel the outraged pain that people experience when they and their land have been flattened by industrial development willed on them by the powerful rich. The physical landscape itself is Seeman's most powerful metaphor, serving both literally and symbolically to show us what is happening to the life of the community. All through the novel Seeman directs our attention to the beautiful rolling green Carolina piedmont, with its rivers and birds and muskrats and beaver, and we must watch as the tobacco town spreads across it like a blister. Near the end of the book, John Anders, the angry young artist-protagonist, stands on the railroad bridge at the town's center and mentally digs down under the concrete and metal to show us what the place used to be. There is a "story in all ground," he reflects. Under the Dukes' proud Methodist church was a Baptist church, and under that a graveyard:

In it Reverend Jesse Judd...gathered with his fathers like a tall slim shock of corn. And with him buried the Mink's Hollow people – hunters, witches, and tale-tellers who could not now even tell their tales – and buried with him, too, the light of a lost and green gold afternoon. The soft sifting of maple leaves – scarlet and yellow – on his pine box Duck Erdmann had knocked up back of the smithy. And all the grasshopper twitter and chirkings and the drone of their crankling flight.

In a chapter like this, we enter deeply into the peculiar anguish of this beautiful yet increasingly ruined section of the country.

Despite its many beauties and its great comic strengths, however, *American Gold* doesn't really hold together as a novel. The book's progress is disjointed and uneven; several chapters, mainly in the last half, add nothing to the story and serve only to distract the reader; and some of the narrative seems to be missing, and with it information which is urgently needed to fill in the character and life of the protagonist.

The book is, or was intended to be, a dialectical combination of two stories. One is the story of the town itself – the Dukes, the factories, the receding forests, the growing squalor and the wealth – told from the viewpoint of a remote, all-knowing observer. This segment of the novel is spectacularly well done; the stinging satire, rich language and vivid detail of the first 150 or so pages carry the reader along into what at that point

really does appear to be a new American classic. Then Seeman introduces the companion plot, which revolves around the life of a sensitive young artist, John Anders. Through Anders, Seeman wants to show us the effects of such social turmoil on an individual. The author has switched his lenses, wide-angle for close-up, and we watch one boy growing up, impressionable, innocent, and easily outraged by the mechanized oppression upon which his beloved crazy-colorful town is built.

It's a great idea. But it doesn't succeed because the John Anders half of the story doesn't come anywhere near being fully developed. We first encounter Anders as a little boy and are given a vivid and memorable picture of his initial encounters with the town, and his Tom Sawyer-like adventures in the surrounding countryside. But from that point on we glimpse Anders only in brief, perplexingly unfocused snatches, interspersed with passages of reminiscence about a now defunct opera house, and descriptions of various parasitical fine ladies, against whom Seeman appears to harbor a particularly pronounced grudge. There is a short love affair between Anders and a rebellious older woman, but it doesn't reveal much about Anders' psychological growth or his relationship to the town, and Seeman describes it with awkward and uncharacteristic sentimentality.

We are told that Anders stands in a difficult love-hate attitude towards his town. But Seeman simply never shows us enough of Anders' mind to make this believable. In contrast with Faulkner's Quentin Compson, another Southern artist-figure who achieves tragic dimensions trying to articulate a vision of the South ("I dont. I dont! I dont hate it! I dont hate it!"), John Anders remains a one-dimensional figure whose sporadic rages and meditations have a decidedly self-righteous ring. There is one great penultimate chapter where we see Anders on the railroad bridge, brooding over the town like its disembodied conscience. But this episode stands in virtual isolation, after a period of several years (we don't even know how many) about which we are told absolutely nothing. We want to believe in Anders, to see in him a real struggle to confront the beauties and inequities of his native South. But it's impossible to believe in a character whom we never really know.

American Gold is very much like the rough first draft of a great American novel. Parts of it – mainly the sections about the Dukes and the Durham boom – stand perfectly just the way they are. But one turns the last page with a strong feeling that this is an unfinished novel. Even incomplete, however, it is an astonishing piece of work, artistically as well as politically, and an important literary discovery. □

"A Redhot Poker and Rattlesnake Juice"

A Profile of Ernest Seeman

By Mimi Conway

When I first went to Tumbling Creek, Tennessee, to see Ernest Seeman, his wife Elizabeth cried. "You are too late. His beautiful, beautiful mind is gone."

I had been sent by Jacquelyn Hall, director of the Southern Oral History Program at the University of North Carolina at Chapel Hill, to tape Ernest's recollections of his fifty years in Durham, North Carolina, his knowledge of the Duke family and its tobacco monopoly, his founding of the Duke University Press from which he was fired in the 1930s because of his nonconformity, and his experiences living in the Tennessee mountains with his second wife for the last forty years.

At our first meeting, Elizabeth told me that weeks before, her husband had tried to lock her out of their cabin in his attempt to burn it down and destroy both himself and the unpublished manuscripts representing his life's work. Reluctantly, Elizabeth had had to commit Ernest to the care of a nearby nursing home. Despondent, with no conversation available deeper than cursory pleasantries, Ernest slipped further and further into the recesses of his own mind. Under the circumstances, I told Elizabeth, I understood that making an oral history tape of Ernest was out of the question. But when she told me he missed "the company of young people," I agreed to visit the old man in the home.

I found Ernest slumped in a wheelchair, a visor pulled far down on his high, round forehead, dazed and confused. It was in January, 1976; he was eighty-nine years old.

Our first meeting was brief, but even then something about the man prompted me to say I would stop by to see him the following afternoon. The next

The Seemans early in their marriage in their Tennessee cabin.

day, to my surprise, I found the old man thumbing through a tattered **Newsweek**, searching for the grist for conversation. Because Ernest was hard of hearing, conversation was difficult, but I was moved by the obvious fact that he was trying desperately to communicate. As he and I talked, Elizabeth Seeman came in. She was stunned by the change in Ernest; it was the first time since he had been at the nursing home that she had seen anything of his old vitality. "Maybe it's not too late," she suggested. As we discussed the possibility of a taped interview, Ernest seemed enthused, and so the project began.

I used only a notebook in the almost daily sessions which followed. At the outset, Ernest could not remember when events happened, although he could describe incidents vividly. But gradually, in response to daily questioning, his mind sharpened. "Come on, memory," he would sometimes say, prompting himself. "Come on, come on."

During this preparatory period, I journeyed frequently to Tumbling Creek to verify and clarify with Elizabeth the jumble of information Ernest had given me. After one such session, Elizabeth extracted from the clutter of the cabin's floor-to-ceiling shelves two packets wrapped in brown paper and tied with frayed string. Inside were flimsy cardboard boxes holding the typed manuscript of *American Gold*, originally called *Tobacco Town*.

The sun was already going down in the hollow when Elizabeth handed it to me. Faced with an icy road and growing darkness, I skimmed the novel quickly, taking notes on the characters which Ernest had told me were drawn from life.

Finally, on February 13, 1976, after three weeks of preparation, Ernest Seeman recorded his life story during a three-hour taping session for the University of North Carolina. After the tape was made, my work was done. But something else had happened; in my brief visits to Tumbling Creek, I had gotten a glimpse of the rough-hewn, natural life these two people had carved for themselves. I continued visiting Ernest and Elizabeth Seeman, now with an awareness of how deeply they had affected my life. I recognized, too, that in sending me down that road to Tumbling Creek to do an oral history tape, Jacquelyn Hall had provided me with tools for exploring the social, economic, religious and psychological reasons why people take actions that change the course of human events in that catalytic way that makes history.

Ernest Seeman

For a decade before I met the Seemans and Hall, I had been a journalist. Recently I had become discouraged, almost immobilized, by the limitations of the who-what-when-where-how approach of daily journalism. The Seemans' integrity and stamina and Jacquelyn Hall's vision of history sent me back to my craft with a new sense of purpose.

On one visit to Tumbling Creek, I reread *American Gold*. This time I curled up by the large stone fireplace and stayed two days reading Ernest's work. I read *The Bull and The Thrush* and *Grasshopper Farm*, which with *American Gold* comprise the trilogy that both Ernest and Elizabeth view as his life's work.

Reading Ernest's delicious, earthy North Carolina language, I was convinced I had read a masterpiece in *American Gold*. Elizabeth told me that Ernest had tried to get it published a number of times and had failed. Now the couple no longer had enough money to send out the manuscript. I promised to help, and on my next visit to New York, Joyce Johnson, executive editor of Dial Press, agreed to read the Seeman manuscript. She was as excited by it as I was; shortly afterward, Dial accepted *American Gold* for publication.

Bull Durham

The novel, *American Gold,* depicts a mythic town of tobacco magnates as seen by Johnny Anders, a Warham printer privy to their wheelings and dealings. When we last see Anders, he is near forty and restless, walking through Warham, a city of the New South. Like his character, Johnny Anders, Ernest Seeman was himself a printer for many years in Durham, North Carolina, and the linchpin event in Seeman's own life – his dismissal as head of the Duke University Press – took place just outside the action of the closing chapter of *American Gold.*

When Seeman was thirty-seven years old, he left the Seeman Printery, started by his father, Henry, to head the new Duke University Press. On the surface, the choice of a printer with little more than a seventh grade education to head a university press seems peculiar, but Ernest was known as an intellectual in his home town and, more than that, the Seemans had long ago proved their loyalty to Durham's tobacco interests.

Ernest Seeman was born in 1887, in Durham, N.C., just in time to witness the Duke family's rise to power. Three years before Ernest was born, W. Duke, Sons and Company had introduced mechanization into their small cigarette business. The Bonsack cigarette rolling machine produced 120,000 cigarettes a day, the equivalent of forty hand-rollers working ten hours. And the Dukes had a secret agreement to lease the machines for twenty-five percent less than any other manufacturer.

Since the lease was a closely guarded secret, known only to the Dukes and Bonsack, nobody could anticipate the effect which it would have on the marketplace in the years ahead. But the impact of mechanization on tobacco workers was anticipated from the outset. In 1884, historian Hiram Paul heralded the arrival of the first Bonsack machine with his ominous prophecy: "Its effects upon another class of our fellow-citizens will be anything but gratifying to the true philanthropist. Thousands of girls, boys, men and women, and among them worthy orphans, widows and decrepit old age, will be thrown out of employment, many of whom are, to a large extent, disqualified for the prosecution of other industrial pursuits. There are scores of widows wholly dependent

upon the pittance earned by their children in the cigarette factories. The shock may be temporary, but it will nevertheless be a severe one."

The advent of mechanization helped fuel the expansion of the Duke family business into the American Tobacco Company, a giant holding company organized under J.B. ("Buck") Duke, which, at the height of its power, controlled nearly ninety-five percent of the US cigarette business and four-fifths of the entire tobacco industry. Buck Duke's "Tobacco Trust" remained intact until 1911, when the US government prosecuted the American Tobacco Company for violating the Sherman Anti-Trust Act. By that time, the Dukes had already heavily invested in textiles and water power and had parlayed their tobacco fortune into the base for the future Duke Power Company.

Durham's self-image as "the Chicago of the South" was wholeheartedly endorsed by Ernest's father, Henry Seeman. Up until the mid-1880s, he worked for W.T. Blackwell and Company, whose "world's largest cigarette factory" dominated the town. He built up his small printing concern making the labels for the Blackwell's famous "Bull Durham" smoking tobacco. And when the Dukes came to power, he worked for them, too.

In 1889, Henry Seeman launched the **North State Artisan,** a monthly journal devoted to the development of the South. "Our main objective," the publication stated, "will be to aid in promoting every manufacturing enterprise that will provide a benefit to themselves, to our people and to the South."

From these ventures and his printing contracts from the Duke family, Henry Seeman built a business that even today handles printing contracts for Duke University and the area's tobacco companies. Henry Seeman's career started and ended with tobacco interests.

In 1917, when Ernest was thirty, Henry Seeman died, the victim, according to his son, of industrial poisoning. "He had printed the Bull Durham labels. That's what killed him. He had a little tray of bronze in his printing office. He'd take a piece of carton and dip it onto the bronze and rub it over the printing so that the ink would pick up the bronze. That's what made those labels shine like gold. The doctor said that stuff had gotten into his lungs." After their father's death, Ernest and his brothers Henry and Wallace took over the family printing business.

As Ernest remembers it, "One day my brother Wallace was down at the Seeman Printery, and he got to talking to Professor Flowers (later Vice President of Duke University). Flowers said, 'In building up our organization, we're going to need a man to head up the Duke Press, and it looks to me like Ernest would be just about the man. He's scholarly, and he's had a lot of experience in reading and travel. See what he thinks and send him to me.'

"So I went to see him, and he said, 'Yes, we do need a man. We won't give you a full-time job, but we'll take you on half-time.' I said, 'I don't work half-time for anything.' I took the job and began to organize it. They gave me a little office by some old mathematics professor's den." Duke was notoriously tight-fisted and for two years paid Seeman an annual salary of $2,500, half-time pay for his full-time work.

At the time, Duke had every reason to expect that Ernest Seeman would do its bidding. True, Seeman had a quirky intelligence, but he had also immersed himself in the Durham "society" newly created by the sudden prosperity of the tobacco town. He appreciated beautiful women and custom-made suits. And he seemed to share his father's belief in a New South based on industrialization, the kind that started Durham in the first place. As Ernest put it, "My father was gentle, and they thought I'd be the same."

"Livening Things Up"

Seeman's difficulties with the Duke University administration began innocuously enough. One day, shortly after he was hired, Ernest wandered into the office of Alice Mary Baldwin, the dean of women. He said, "Miz Baldwin, this is the dullest place I've ever been in. There's nothing here but prayer meetings and football." The dean of women asked the blond, bespectacled fledgling publisher what he suggested as a remedy. "I don't know," Seeman told her. "I'll think about it and tell you in a day or two."

Before the week was out, Ernest had printed up invitations to about fifty students and faculty members to come to a watermelon feast. He remembers the evening vividly. "It was an October night, and the moon was shining. An old great-horned owl hooted. That was thrilling. The students loved it because they were getting some action. One crowd built the trestles to put the watermelons on and another cooked up the beef steaks."

The advent of mechanization helped fuel the expansion of the Duke family business into the American Tobacco Company, a giant holding company organized under J.B. ("Buck") Duke.

Students and faculty, organized by Ernest Seeman and Alice Mary Baldwin, continued their outings. By 1931, their Explorers Club had become a popular institution with a regular schedule of bi-monthly outings. Ernest had succeeded in "livening things up" on the Duke Campus. But if the head of the new Duke University Press was popular with students, he was far from appreciated by Duke University President William Preston Few.

From the beginning, the quality in Few most appreciated by the Duke family was his loyalty. When Few first came to Trinity College (the Methodist school which later became Duke University) as a young Shakespearean scholar fresh from Harvard, Ben Duke – and not Trinity College – paid his salary. And in 1910, when Few was made president of Trinity College, Ben Duke saw to it that Trinity was placed at the top of the list of the Duke family's philanthropies. In the spring of 1921, Few drew up a document he hoped that Ben Duke would sign – the papers which provided for the expansion of Trinity College into a full university which would bear the name of the wealthy Durham family. Ben Duke promptly gave his approval, but Few had a hard time persuading the more canny and powerful J.B. "Buck" Duke to turn over the lion's share of the Duke Endowment to the school.

On December 11, 1924, J.B. Duke signed the deed creating the Duke Endowment with securities worth $40 million. Of the total annual income earmarked by the Endowment for education, thirty-two percent was designated for an "institution of learning to be known as Duke University." The deed

Back of it all was the issue of who was running the University – its own trustees or the Duke Endowment which had given the school $40,000,000.

noted further that "should the name of Trinity College be changed to Duke University" within a three-month period, then $6 million should go to that institution. A year later, after "Buck" Duke died, President Few wrote to Ben, the last surviving son of Washington Duke:

> You are in my mind every day. While Duke University itself is a wonderful monument to you as well as to your Brother, your Father and the Duke family, still much of the life that remains to me I am going to devote to an effort to build up for you here in Duke University a personal memorial of magnitude and permanent significance enough to be in all generations a reminder of the greatness of your spirit and the greatness of your deeds. This undertaking will grip my heart as nothing else here grips it.

"Buck" Duke

What Few did not mention to Ben Duke was the thorn in his side on the campus. Ernest Seeman and a growing number of younger faculty members did not share Few's vision of making the University a personal monument to the Dukes.

Few had found in Ernest Seeman a dire enemy, and eventually a scapegoat. Years later, Ernest recalled their basic disagreement. "We were diametrically opposed on education. He was everything for the establishment, and I wasn't. I'd combat him."

In November, 1933, a satirical play called "The Vision of King Paucus" was distributed on the Duke University campus. It was a thinly disguised (*paucus* is Latin for "few") parody of the top University administrators and their relationship with the Dukes. The play opens with "candles burning under an oil portrait" of "a huge coarse-looking man with a wad of tobacco in one cheek" as King Paucus, Prince Blossoms the Eunuch and little Willie Wanna-be-King kneel on a ten thousand dollar oriental prayer rug."

> *"Glory be to Buck Duke in the Highest,*
> *Glory be to the Virgin Dollars we are salting down for our old age!*
> *Glory be to the Holy Spirit of the Ballyhoo that enables to keep*
> *The American Public in the dark...."*

President Few, Vice President R. L. Flowers and Dean W. H. Wannamaker, targets of the parody, were incensed.

Few tried on his own to uncover the rebels. Ernest Seeman recalled, "Suddenly Few appeared at the Explorers Club, unexpected and uninvited. He was not known as an athlete or a naturalist....He was observing, of course, to see how radical we were getting. He couldn't believe we were just gathered together, just walking and exploring nature."

Subsequently Few called Seeman into his office and asked him to write down the names of the students involved in writing the parody. Even today, Ernest is angered remembering the moment. "I told him I'd be hanged first, and walked out."

The Duke Rebellion

In February, 1934, a student rebellion broke out on the Duke campus. Again Few suspected Seeman. Despite the fact that Ernest was in bed ill with influenza at the time, he was the Duke administration's prime suspect. The Durham newspaper during that month reported that Seeman had been "charged directly with being hostile towards the administration, with fostering insurrection among the students and warned to cease such activities. Included in the charges against Mr. Seeman was the intimation that he was connected with the publication of 'The Vision of King Paucus.'"

In a letter written on February 13, 1934, to R.L. Flowers, Vice President of the University, Seeman wrote:

> I am sorry that the general unsettled conditions here have driven you to suspect me of disloyalty to Duke University. In view of the fact that I am not guilty of charges for which you have no basis other than suspicion, I am writing you to insist that the administration discontinue the circulation of such charges against me for the reason that these charges are libelous and are calculated to, and are, defaming my character and standing in this community.... It is my sincere opinion that as long as student protests are suppressed, just so long will internal confusion and unrest continue to spread through the institution."

The immediate issue which sparked the student rebellion seemed trifling: Dean Wannamaker had voided a student offender's trial because Wannamaker had not been present to preside over the inter-fraternity council's hearing of the case. But to the chagrin of the Duke University administration, the root cause of the rebellion on the ten-year-old University campus was reported in the local and national press.

Time Magazine devoted two columns to the Duke rebellion, saying "many a student and restive alumnus saw more to the affair than a youthful outburst, more to the rumored faculty unrest than the squabbles and jealousies which beset every university administration. Back of it all," **Time** said, "was the issue of who was running the University – its own trustees or the Duke Endowment which had given the school $40,000,000."

Using the considerable power of his office, President Few continued his campaign against Seeman. In a letter to the president of Wofford College in Spartanburg, South Carolina, written immediately after the Duke rebellion, Few requested that his colleague check his correspondence to see if Seeman

"whom we have under vehement suspicion" had sent him "news stories concerning Duke University with a more or less unfavorable slant."

Seeman's career at Duke did not end until nearly a year after the publication of "The Vision of King Paucus" and eight months after the student rebellion had disquieted the campus. Ernest described the final days. "One morning, this big old tub of guts, Henry Dwire, head of publicity at Duke, phoned me to come into his office. He was very preemptory. I feared something was going to happen. When Seeman got to his boss's office, Dwire had a letter in front of him. "He said, 'Here. Read this.' He was going to play cat and mouse. He wanted to enjoy the victory. So I went over and read it and looked him in the eye. And I said, 'I'm not afraid,' and I went away." The letter said that Captain R.O. Rivera would take over the Press.

On October 15, 1934, on the day he left Duke University, Ernest Seeman wrote to President Few:

> I am leaving the University today. In doing so I must thank you very warmly for many fine opportunities of these past ten years. The pleasant and developing contacts in the college world. The interesting job of nursing a young Press. The very interesting first-hand view of an adolescent University seeking its creative-social levels.
>
> Now and then, to be sure, I may write critically of universities. Along with other evolving institutions, I shall never have any malice in my viewpoint; all institutions belong primarily to the people and are due to be examined and criticized freely. The more open their conduct, the less criticism needed. The more clannish their operation, and the slyer their propaganda, the more criticism necessary to prevent long cycles of error or a natural relapse into feudalism and high priestly ways.

Those who knew Seeman at the time said that within two weeks of being fired by Duke, he turned into an old man, so devastating was the experience of losing all that had been his life. Not only was he out of work during the Depression, but he lost the socially ambitious wife he loved. She had warned him repeatedly that if he ever crossed the Duke family she would divorce him. She proved true to her word.

Broken, Seeman retreated alone to a country house in such disrepair that it was being used by its owner to store hay. The roof had holes and it was full of rats. His fallen state aroused sympathy even in President Few, who had worked so hard to discredit him. Answering a colleague's inquiry about Seeman in October, 1936, Few had this to say: "His brother has cut loose from him in every way. His wife has also left him. Altogether he is an Ishmaelite that ought to excite the sympathy and even the pity of us all."

A New Life

Ernest tried to rise above his despondency by concentrating on writing *American Gold*, a book he had been working on while still at Duke. (And like Johnny Anders, the novel's protagonist, Seeman wrote late into the night in a clandestine office in a Durham insurance company building.) When an old friend repaid an outstanding loan, Seeman left Durham for New York, where he hoped to build a new life.

In New York, Ernest met a woman seventeen years his junior. Years later, he remembered as clearly as if it were yesterday the moment he first saw Elizabeth Brickel Klinger: "There she was," Ernest said, "wearing a yellow dress, and a big old tabby cat was sitting on her shoulder." They fell in love, and when Elizabeth, an artist and writer, was offered a job as a greeting card illustrator for a Chicago firm, Ernest followed her, and they were married. Theirs has been a remarkable, strong union for over forty years. For most of those years, they have made their home in Tumbling Creek, Tennessee, on the edge of the Cherokee National Forest.

At Tumbling Creek, Ernest continued writing *American Gold*. But as Elizabeth remembers it, their Tumbling Creek home was hardly a bucolic retreat. "About the time that World War II began, the mountain people assumed – with Ernest's German name – that we must be spies. All sorts of rumors flew. Every drawing I sent off to Chicago had maps for spy material. Every bird house we put up was a way of talking to Italy, Germany or Japan. It was becoming a very dangerous situation.

"The fact that we were being investigated by the FBI put us in more danger," Elizabeth added, although their investigation had little to do with "German spy" rumors. "Actually, they were investigating us because we were radicals. They saw we got a vast array of all sorts of different magazines of every persuasion of thought, from the most radical to the most conservative. They had the mailman check our mail, and if we sent a radical paper to anyone, he would go there and say, 'Now you shouldn't take that paper.'"

Many years later, happenstance brought Ernest together with one of the agents who had trailed him decades before. The two men met as patients in the Veterans Administration Hospital in Johnson City, Tennessee. And the agent, making conversation, told Ernest: "We really couldn't get anything on you except you read too much and your interests were too wide."

Those who knew Seeman at the time said that within two weeks of being fired by Duke, he turned into an old man, so devastating was the experience of losing all that had been his life.

In 1971, in a letter to his former secretary at Duke University Press, Ernest shared his thoughts about the past, and his continuing interest in the policies of his former employers:

> Strange, isn't it, how years *after* innovations happen, people are glad to know about them. After the old lords are dead and in heaven, and the young rebels have taken over. This past Easter, several people were here from Duke and told how President Terry Sanford is doing a good job. Putting youth on all committees and demoting a lot of the old stuffed shirts trying to turn the clock back. Hurrah.

The letter included a postscript which reflected Ernest's continued involvement and concern with the larger community around him.

> P.S. You may be interested to know that in late May the Appalachian Movement Press, of Huntington, W.Va., is publishing my 150-page article titled **"What's Next?"** They will sell it for $.75 – the proceeds going to the black lung and anti-strip mine cause. The article is about what's happening and is *going* to happen to the Great (and phony) American Empire, that great sausage-grinder grinding up our boys and millions of poor Vietnam peasants so the Oil Trust can get more oil and Tricky Dick can get all the power there is in the world. ...I have no financial interest in it (the article). I just wrote the piece with a redhot poker and rattlesnake juice.

With the publication of his major work, *American Gold*, Ernest Seeman leaves us the legacy of his "red-hot poker and snake juice." And like one of the marvelous characters we briefly glimpse in his novel, this ninety-one-year-old North Carolinian demonstrates his own "fresh, unwilted way of seeing life." □

Pissing in the Snow and Other Ozark Folktales

By Vance Randolph. University of Illinois Press, 1976. 153 pp. $7.95.

By David Whisnant

For more than forty years, Vance Randolph collected folklore in the Ozarks. Most of it was published in the 1950s in a series of volumes bearing the prestigious imprint of the Columbia University Press. But a lot of it wasn't; it was bawdy lore which no respectable academic press (and few presses of any kind) would touch. So after Randolph completed the text of this volume in 1954, it circulated privately in manuscript and microfilm for nearly twenty-five years until changing mores and the enthusiasm of a young folklorist, Rayna Green, resulted in its publication as *Pissing in the Snow*.

David E. Whisnant teaches American Studies at the University of Maryland.

Unlike many scholarly books, this one can be read at many levels and for a variety of purposes. The first (maybe the best) is for sheer delight, and Avon's paperback edition may make that possible for a wide audience. For whatever else it may be, it is a book about the time when Billy Fraser got his pecker stuck in Judge Patterson's daughter's twitchet, about the man who had a baby, glory poles and tee-hees, a good dose of clap, the miller's prick, why God made stickers, and the brag heifer and the speckle-ass bull.

What a pleasure to be able to read with impunity (not to mention Higher Critical Purpose) the kind of thing you once nearly got expelled from school for circulating in block letters on

A Return Visit:

When Howard University granted Lillian Smith an honorary Doctor of Humane Letters, part of the citation read: "You are a dangerous revolutionist. There is enough dynamite in what you say to blow up the very foundation of segregated civilization." This "indictment" of Smith was purposely overstated, but still contained a good deal of truth. Throughout her life, Lillian Smith worked for what many considered a revolutionary ideal – the destruction of the social barriers of racism which warped the lives of both the oppressed and the oppressors.

But Smith was far from what most people nowadays consider revolutionary. She was no socialist or anarchist. Her enemy was segregation, not capitalism, and what she was after might best be called psychological freedom, having little to do with economic factors. A citation from Western Maryland College, awarding her another honorary degree, nicely summed up her career: "Motivated in no way by political opportunism or self-interest, but rather by a deep philosophical purpose and conviction of right, this daughter of the South, through novel and essay, by personal living and eloquent word, has given articulate expression and sympathetic challenge in behalf of the God-given dignity and freedom of each human personality."

It was pointed out in a recent issue of *Southern Exposure* (Vol. IV, no. 4) that during Smith's whole life she never gave up struggling to liberate people's minds and souls. Born in Jasper, Florida, she later adopted Clayton, Georgia, as her home – it became the base to which she always returned after working or traveling elsewhere. During a busy lifetime, she directed a girls camp, worked unsparingly for the civil rights movement, and founded with Paula Snelling a journal of literature and politics, which, after several name changes, became *The South Today*. But most significantly, Lillian Smith was a writer, and a good one. She published countless articles, five books of nonfiction, and two novels – all this in spite of the fact that a good deal of her work was destroyed in the fires that twice struck her home. It is Lillian Smith as a novelist that I want to talk briefly about here.

She felt that a novelist should have a social commitment. To write a novel that did not actively confront the social problems of the time was to Smith a shocking dereliction of one's duty to help improve humankind. Her own two novels illustrate her convictions. *Strange Fruit* explores and exposes the disastrous effects of racism on the population, both black and white, of a small Southern town, while *One Hour* illustrates the entangled web of hate, fear, and prejudice which is spun out when another Southern community embarks on a witch hunt reminiscent of the hysteria of the McCarthy era.

Psychoanalysis greatly interested Smith and informed her role as a novelist. She, as doctor, tried to help her patient, the readers (or more generally, society), by bringing their problems to light; she held up a mirror to her readers which revealed their moral cowardice and the destructive nature of their prejudices. Readers could respond either by throwing down the book, or as Smith hoped, by opening themselves to change.

Unfortunately, a good number of people did throw down the book when *Strange Fruit* was published in 1944. The novel was immediately banned in Boston and, for a short while, prohibited by the Postal Service from being sent through the mails. The story focuses on Tracy Deen, a well-to-do white youth, and his love affair with Nonnie, a young black housekeeper, by whose brother he is subsequently murdered. But the narrative pans out to show how Tracy's and Nonnie's story, and the agonies of a segregated society which their situation embodies, touch the entire town. We ride a narrative merry-go-round, switching from one character to another, being presented with a multiplicity of perspectives on Tracy's and Nonnie's

crumpled sheets of notebook paper. The only detail I recall from our little stash of erotic lore was that in one of the tales he had balls as big as oranges. But I remember vividly that our short essay into erotica earned us a trip to the principal's office. There, failing utterly to recognize our status as informants who could offer access into Folk Tradition, he lectured us sternly, threatened to call our parents, destroyed our embryonic collection before our eyes, and concluded, "I'm asha-a-a-med of you, boys and girls." Yes, girls.

But beyond pleasure and reminiscence. *Pissing in the Snow* has a multitude of other values. It comes with sufficient scholarly apparatus to allow one not only to place the tales in the context of Randolph's other work (and therefore of folklife in the Ozarks), but also to relate them to the small but growing body of scholarly work on erotic folklore in many cultures. Rayna Green's introduction manages to be at once learned and sensitive, analytical and passionate. Randolph's brief headnotes tell where and when he heard the tales, and Frank A. Hoffman's meticulous annotations relate them to the standard folklore motif indexes as well as to specific cross-cultural variants and pertinent discussions in folklore scholarship.

Pissing in the Snow should be of interest, though, not only to professional folklorists, but also to anyone who wants to understand culture in the South. We have been hillbilly-ized and *Tobacco Road*-ed and *Deliverance*-d so persistently that it is time to re-evaluate the actual variety of ways in which Southern men and women have understood their sexuality. Bawdy tales from the Ozarks won't tell us all we need to know, but they tell us much. For a start, instead of unremitting sexual degeneracy, dysfunction, and violence, they offer evidence that at least a few of the healthier ones of us have been capable of acceptance and joy. Sodomy and incest? No doubt, here as elsewhere. But also, Randolph's Ozarkers tell us, laughter and a lot of good fucking. □

Illustration from *Strange Fruit*

Lillian Smith

By Bob Brinkmeyer

predicament, which remains always at the center.

The furor over *Strange Fruit* was due in part to the explicitness of the language (mild by today's standards), but there was also another, more significant reason. Many people, set in their ways, resented Smith's portrayals of characters who did not measure up to their expectations of them. Smith's strategy was to take fairly standard character types of a Southern town, and by making their predicaments real and complex, show how racism stunts everyone's growth. Her "heroes" turned out to be almost as unattractive as her "villains," and nobody emerged clean.

Her readers (black and white) were disturbed when the characters they identified with did not perform as expected. This was especially true with *Strange Fruit*, which, in Smith's words, forced the reader "to identify ...with a character or situation unflattering to self-esteem." She hoped that through this process of identification and disillusionment readers would see more clearly their own shortcomings and become aware of how racism poisons the lives of *all* Americans. Of course, many readers responded to Smith's therapeutic strategy by attacking both her and her books, insisting that since *Strange Fruit* was bad for the *status quo*, it had to be suppressed.

If *Strange Fruit* illustrates Smith's idea of the first step in one's struggles for wholeness – stern self-scrutiny – then *One Hour* represents the second step – the constant reappraisal of the past and present, necessary to understand the workings of the world and our places in it. Perhaps partly because of the indirect, meandering nature of the reappraisal process, *One Hour* does not succeed artistically nearly as well as *Strange Fruit* does. Though in *Strange Fruit* there are patches of sloppy elliptical writing, Smith tells a powerful story with great sensitivity and vigor. *One Hour*, by contrast, is much too long, its narrative padded with tedious philosophical digression. When read solely for its ideas, however, rather than as a work of art, *One Hour* yields valuable insights into Smith's thought.

One Hour is the story of a Southern town and its near hysterical reactions to a scientist who has been accused on scanty evidence of molesting a young girl. Reverend David Landrum (the narrator of the novel) becomes a detective figure, actually and psychologically, in his efforts to discover what really happened during the one hour when the assault is supposed to have occurred. At the same time, he must try to hold off the rising flood of public resentment against the accused and his family. (The scientist is quickly associated in the public's mind with blacks and communists.) Reverend Landrum soon realizes that fear and prejudice, coupled with the faultiness of communication between people everywhere, create a maze of barriers which confine people to narrow and stifling corridors of psychological existences. Quickly caught up in the maze himself, Landrum struggles fiecely to cut through and master the puzzle. His fate, the ongoing struggle to perceive life as a whole, represents to Smith a universal predicament. It's our duty, she believes, to fight to free ourselves – and others – from the nets which keep us from taking flight.

The failure to work for others after one liberates oneself is for Lillian Smith the unpardonable sin. She treats with harsh irony figures such as Prentice Reid, the newspaper editor in *Strange Fruit* who can see very clearly his society's sickness, yet refuses to risk anything to correct it. Reid's own words, as he finishes a milksop editorial when stronger sentiments are needed, represent the *laissez-faire* attitude which Smith condemned most sharply: "'That'll fix it,' he said aloud, and laid the copy on the table. 'Puts right on our side. Makes us all feel sorry for ourselves. Well that's what they want, and *The Maxwell Press* aims to please.'" Lillian Smith never aimed to please. She worked to change people, to give them not what they wanted, but what she thought they needed. □

Witness in Philadelphia

By Florence Mars, with the assistance of Lynn Eden. Louisiana State University Press, 1977. 296 pp. $10.00.

By Margaret Adams

One of the few larkish escapes from the sedate routine of Blue Mountain College was to be permitted to meet the Rebel, a famous passenger train which rolled below our hillside campus on its nightly run from Memphis to New Orleans. Infrequently, some passenger would get off at Blue Mountain, Mississippi. Were it not for the college, Blue Mountain would hardly have warranted a stop. Missionaries and solid Southern Baptists sent their daughters, trusting that they would be securely shielded from both men and ideas.

In the event some passenger was coming to the college, and we had arranged successfully with college authorities to meet the train, we students were certain of adventure and reward. To be off campus by ourselves with the college's car at night was daring risque – an event permitting us to be the first to know the new arrival or visitor. We were assured, too, of seeing the night watchman, who delighted in telling us at every opportunity about how he'd killed "the nigger" with the pistol always slung at his hip.

He was one of "them." Florence Mars describes "them" and "us" perfectly in this meditation about how and why on June 21, 1964, three young men, James Chaney, Andrew Goodman and Michael Schwerner, were shot and killed, then buried under a red clay embankment outside of Philadelphia, Mississippi. "They" committed the murders; "we" conspired with them in our entwined history. Mars' book is about this turning point in Southern history; it is about Neshoba County, and its county seat, Philadelphia – her home and her family's home. She could have been writing about Blue Mountain, or New Albany, where I was born, or Hatchee, where my grandfather had lived until it became plain to him that it was no place to bring up his family.

"We" were from "good" families. "We" were taught to respect the law, to attend church regularly on Sunday and Wednesday evenings, to abide by standards of cleanliness and etiquette. "They" were mean, coarse, fearful, often poor and hungry, but certainly capable of any violence. "We" were created to set the example for "them," to demonstrate how to exercise restraint. "We" set "them" apart, just as together all whites set blacks apart. Florence Mars knows this history, too. She is one of "us."

Because she is, her book goes beyond a mere rehashing of the grisly killing of three civil rights workers, or the tense months leading up to that event. She tells *why* the killings happened. They were not the result of a sudden spasm of hatred, but rather the result of a historical process which had pitted class against class, and race against race. "We" did not like what the blacks were proposing in the '60s with the federal government's backing, so "we" formed the White Citizens' Councils, or preached interdiction, or raised the spectre of once again pulling out of the Union. Taking "their" cues from "us," the supposed exemplars, "they" revitalized the Klan, intimidated, burned and, finally, murdered. "We" refused at first to believe murder had been done, and when FBI agents and hundreds of Navy recruits finally closed in on the graves, "we" excused the slayings as the work of outsiders.

Florence Mars, obviously hoping that others of "us" would join her in fulfilling "our" historic responsibility to restrain passions, stepped aside from Philadelphia's flight from reason. She felt the necessity to speak about the murders first with family, then with newsmen, then secretly with the FBI, and finally in public with a federal grand jury. By her own admission, she did not know much, but the mere fact that she talked cast her outside the history of "them," and for a time, "us." She was labeled a COFO (Council of Federated Organizations, an umbrella group of civil rights organizations), an epithet spoken with bitterness by white Mississipians to this day. Her Methodist church made it known she was unacceptable as a Sunday School teacher. Friends of long acquaintance spurned her company. A boycott forced her to sell her business.

"Their" arrogance, however, eventually turned the tide. Neshoba's sheriff, Lawrence Rainey, whose election was a demonstration of the political clout of the county's bootleggers and Klansmen, got too big for his britches. He arrested Florence Mars one night outside the Neshoba County Fairgrounds. After stopping her, Rainey yanked her from her car. Years later, as she wrote about the incident, the "us" in her was barely concealed: "The idea of such harassment of a Southern lady was unheard of," she said, outraged still.

She was handcuffed, taken to jail, and with her companion in the auto that night, charged with public drunkenness and resisting an officer, and forced to spend the night in a poorly-lit cell complete with open toilet, despite attempts by their families and lawyers to have them released. This was her lowest point. "I had been disdainful of Rainey and certain that I was immune to his travesties," she writes. "Now he had thrown me and Mary Ann in jail, and we were powerless to do anything about it. I had challenged the Klan, and I had lost...I cried in disgrace and defeat and told Mary Ann that I was through – to hell with the town, the Klan could have it for all I cared. I really felt bad that Mary Ann had been jailed because of me and was furious that I had put myself in a position to be arrested."

Rainey had gone too far. By arresting Florence Mars and Mary Welsh, he had breached the wall between "them" and "us." Florence's community rallied to her support. Her cousin, a lawyer who later helped defend Rainey and the others charged with violating the constitutional rights of the slain civil rights workers, sounded the counterattack – "You've been persecuted for over a year and by God it's going to stop!"

Gradually, "we" reasserted "our" position in Neshoba County. As the glare of publicity surrounding the tragedy dwindled, and after Rainey and the others on trial with him had been sentenced to prison terms, the murders and that time of unspeakable irrationality were never mentioned again until Florence Mars published her remarkable book. Much had happened in Mississippi, but little had changed.□

Margaret Adams grew up in Neshoba County, Mississippi, and now lives in Gatesville, N.C.

drawing by Leah Palmer

Brother to a Dragonfly

By Will D. Campbell. The Seabury Press, 1977. 268 pp. $9.95.

By Raymond Gavins

Like the wide-winged chicken hawk which sweeps down from the sky and grabs young chickens, killing them instantly and quickly disappearing with the prey, the dragonfly catches and eats mosquitoes. Known as a 'skeeterhawk in Mississippi vernacular, the dragonfly is the quintessence of speed and motion and restlessness. Perfectly attuned to life on the wing, it works, plays, mates, and eats in flight, never resting. With protruding eyes which occupy more than half the surface of its head, the carnivorous little creature is swift, agile, and skilled in dodging, yet is still frail. It is endowed with six legs, but it cannot stand upright or walk, and can only cling to something stationary when it is not speeding through the air. Yet, by virtue of its control of the mosquito, the dragonfly helped to make possible human settlement and survival in near tropical Mississippi. In the order of things, therefore, it is both predator and protector. Thus Will Davis Campbell metaphorically describes his rambunctious brother, Joseph Lee Campbell, as a dragonfly in this compelling book about the worlds they knew.

In the *Prologue*, author Campbell invokes solemnity. Using Biblical phrases and poetic descriptions, he introduces Joe, himself, and four stalwarts from the Campbell family — Grandpa Bunt and Grandma Bettye, Grandpa Will and Grandma Bertha. There were others, including Joe and Will's mother and father, but the grandparents stood out as survivors. Besides roots, it is not clear what the old ones gave to their grandsons. Unmistakably, though, they instilled within the boys the social values of proud Amite County, Mississippi, white folks. Over the years, Joe and Will were to travel in different directions — Joe, in a hurry, would die prematurely; Will, always prudent, would never escape inner conflict and pain. "Somewhere, something went wrong."

Section one, entitled *Morning*, properly begins the brothers' pilgrimage toward manhood. Against the backdrop of the hills of south Mississippi, Joe and Will ran barefoot in sticker races, once exhumed a 'skeeterhawk buried alive, heard tall tales of murder and hanging and tried their own hand at telling them, and learned from Grandpa Bunt that niggers were to be regarded as colored people since the Civil War was really over. Land and woods, space, as well as strong ties of community and family, loomed large in their lives. For Will, easily, Joe was the significant other. Daring, adventurous, unruly, Joe loved the girls, the woods, and Moore Pasture, where he and Will frequently retreated. "It was the middle of the great depression and Joe and I knew something wasn't right."

Dislocation brought by the Depression caused hardship for the family. Joe ran the farm, plowing, planting, cultivating, and harvesting in place of his father, who was demoralized, jobless, on relief and sick. The young, wily farmer tried unsuccessfully to whip Leon, the twelve-year-old Negro wage hand, protested federal encroachments and led the pranksters at school. White children, at least in Mississippi, simply did not know they were backward and infested with hookworms and were supposed to use governement-built johns and eat hot lunches, although they complied as best they could. Joe grew strong and confident, Will sickly and deferential. And both were acutely aware of the Ku Klux Klan and the inferior status of blacks, witnessing the double standards of justice and the loud cries of a black mother whose son Noon Wells, had been violently killed by his own kind. "And they were sounds which would not soon depart from us." Will's special sensitivity to those sounds — and the black man's plight — set him apart from Joe even then.

Section two, *Midday*, expands upon themes of family discontinuity, identity and race. When Will was fifteen, Joe went to work in the Civilian Conservation Corps camp at Brookhaven. There, as a clerk typist, Joe escaped the drudgery of the farm, never to return. His life, increasingly hedonistic, moved fast. Will, on the other hand, turned to writing, introspection, and the ministry as if to fill the void created by Joe's departure. Following a stint as preacher in two CCC camps, opportunities which Joe had arranged for his younger brother, Will attended Louisiana College.

During World War II, Will made a valiant attempt to identify with Joe by enlisting in the Army. Drafted very much against his own judgement, Joe remained antagonistic toward the Army and the war. "Don't do it, Will. Please. For my sake," he shouted. "For Mamma's and Daddy's sake. For God's sake. Dammit, Will. Please don't get into this mess." Will got in — as a noncombatant; his experience was qualitatively different from Joe's. Joe saw racial segregation and white prejudice but, after being wounded and honorably discharged, made his peace with the white mores of Mississippi. Will emerged from the war determined to end racial injustice. "I knew that my life would never be the same. I knew that the tragedy of the South would occupy the remainder of my days."

Ideologically divergent, yet close as brothers, Joe and Will soon found themselves in the vortex of the race problem. The University of Mississippi, where Will became chaplain in 1954, provided no support for the crusade against bigotry and the White Citizens' Councils. So he moved to Nashville and set up a Southern office on race relations for the National Council of

Raymond Gavins is Associate Professor of American and Afro-American History at Duke University, and the author of Perils and Prospects of Southern Black Leadership.

Churches. As part of the small vanguard of white liberals in the early phases of the civil rights movement, Will knew of black fear, federal ignorance of local repression, and the importance of direct action protest. Through it all, Joe, now a pharmacist, worried for Will's safety, became extremely protective of the entire family, and began to depend upon amphetamines to get him through each day. In one sense, however, Will had taken Grandpa Bunt's preachment, that the Civil War was over, to its logical conclusion. There were no more niggers or colored people, only human beings in Mississippi and the rest of the South who wanted to be free. To many of his own people, some within his own family, Will's position raised the dread spectre of interracial brotherhood.

Section three is appropriately called *Evening*. Here Reverend Campbell provides a moving narrative of his involvement in civil rights, while simultaneously recounting Joe's gradual demise and his own desperate struggle to retain a sense of purpose. It was a time of testing for the whole family and Will seemed to carry the heaviest burdens. The first serious shock came when a nephew died from an automobile-bicycle accident. "I was the only one crying," Will states. "The others stood around...looking at me in stunned silence."

Feeling defeated, bewildered, and worn out, Will also saw a lot of pain and injustice and suffering in the Movement. Encompassed by disappointment, he found the strength to pull through. Joe had kept to himself for a long time, and with precious little to hold on to, soon succumbed to paranoia in the wake of the nephew's death. He collected guns, started beating his wife, Carlyne, and took hundreds of tranquilizers. Will advised psychiatric help, but not before Carlyne packed up her things and the children and left.

The combination of Joe's addiction and Will's efforts to help created tension between the two brothers, tension which lifted only during their long drives together from home to hospital and back again. Will often told good stories of individuals who overcame adversity or retreated in face of overwhelming odds: Horace Germany, a white minister who received a beating from a mob; black and white demonstrators in Albany, Georgia; a young man in jail who was sexually assaulted by inmates; and Thad Garner, the slickest Southern white Baptist preacher in Louisiana. These elicited occasional spurts of inspiration and coherence from Joe, whose deterioration, despite psychiatric confinement and therapy, continued. Will, further saddened by the escalation of white terror in civil rights, questioned both Christianity and Southern white liberalism. Liberals, he mourned, were trapped between their idealism and history. Unhappily, Joe's death from a massive, self-willed coronary, intensified Will's dilemma.

Preacher Will's *Epilogue* is an analytic confession linking his growth and grief. He says nothing of race, of civil rights issues here. He speaks to human feelings and human issues, bringing the reader back to where it all started.

Brother to a Dragonfly is not a monograph, nor does it resolve Reverend Will D. Campbell's own quest to transcend the barriers of race. But it richly illuminates our understanding of the mind of Southern white liberals in ways which historians have not. Campbell is wise and he knows a lot. By probing the works of people like him, we may yet write the candid history of the South which the region deserves. □

Books on the South

This list is comprised of works published since November, 1977. Book entries concentrate on the winter months and include new publications through May, 1978. Dissertations listed were compiled in the **Dissertation Abstract Index** *during December, 1977 to February, 1978.*

Copies of the dissertations below are available from Xerox University Microfilms, Dissertation Copies, P.O. Box 1764, Ann Arbor, Michigan 48106. The cost is $7.50 for microfilm and $15 for xerographic.

ECONOMICS, HISTORY, AND POLITICS

"The Baton Rouge-New Orleans Petrochemical Industrial Region: A Functional Region Study," by Raymond E. Shanafelt. Dissertation. Louisiana State University.

A Brittle Sword: The Kentucky Militia, 1776-1912, by Richard G. Stone, Jr., University Press of Kentucky, 1978. $4.95.

"Changing Land Use in Downtown Norfolk, Virginia, 1680-1930," by William F. Ainsley, Jr. Dissertation. University of North Carolina at Chapel Hill.

The Colonial Records of the State of Georgia, Vol. 27, ed. by Kenneth Coleman and Milton Ready. University of Georgia Press, 1978. $15.00.

"Eighteenth-Century Alexandria, Virginia, Before the Revolution, 1749-1776," by Thomas M. Priesser. Dissertation. College of William and Mary.

"Employment Improvement, Human Capital, and the Secondary Labor Market Aspects of the Manpower Training Program in South Carolina," by David A. Dumont. Dissertation. State University of New York at Albany.

"Factors in Circulation and Continuity of Leaders: An Analysis of the Dynamics of Leadership in a Mississippi Multi-County Center," by Yedehalli R. Mohan. Dissertation. Mississippi State University.

"Georgia Area Planning and Development Commissions: Local Perceptions of Their Roles in the Federal System," by Lewis G. Bender. Dissertation. University of Georgia.

"Human Capital Formation in the Post-Bellum South," by Geoffrey A. Holt. Dissertation. University of California at Riverside.

"Implication of Changes in Tax Laws for the Intergeneration Transfer of the Farm Firm in Mississippi," by James E. Epperson. Dissertation. Mississippi State University.

Indian Affairs in Georgia, 1732-1756, by John P. Cory. AMS Press, 1977. Reprint of 1936 edition. $16.75.

Industrialization and the Slave Economy: Antebellum Manufacturing in the American South, Volume 5, by Fred Bateman and Thomas Weiss. Jai Press, 1978. $17.50.

"An Interindustry Study of the Mississippi: Economy and Analysis of Changes Between 1967 and 1972," by Robert L. Williams. Dissertation. Mississippi State University.

"Isolation and Development on a Louisiana Gulfcoast Island: Grand Isle, 1781-1962," by Frederick J. Stielaw. Dissertation Indiana University.

The Knights of Labor in the South, by Melton A. McLaurin. Greenwood Press, Inc., 1978. $16.95.

"The Know Nothing Movement in Louisiana," by Marius M. Carriere, Jr. Dissertation. Louisiana State University.

"A Locational Analysis of Manufacturing Activity in the Antebellum South and Midwest," by Raymond L. Cohn. Dissertation. University of Oregon.

"A Longitudinal Analysis of the Harris County (Texas) Supporters of Governor

George C. Wallace," by Charles E. Davis. Dissertation. University of Houston.

"Mill and Town: The Cotton Mill Workers and the Middle Class in South Carolina, 1880-1920," by David L. Carlton. Dissertation. Yale University.

Milledgeville: Georgia's Antebellum Capitol, by James C. Bonner. University of Georgia Press, 1978. $14.50.

Organization Design for Primary Health Care: The Case of the Dr. Martin Luther King, Jr. Health Center, by Noel M. Tichy. Praeger Publishers, 1977. $18.50

Papers of the 1976 History Conference at the University of Mississippi, ed. by David G. Sansing. University Press of Mississippi, 1978. Price not set.

Political Profiles of College Students in Southern Appalachia: Socio-Political Attitudes, Preferences, Personalities and Characteristics, by J. Dudley McClain. Resurgens Publications, Inc., 1978. $11.95.

Political Profiles of Female College Students in the South: Socio-Political Attitudes, Preferences, Personalities and Characteristics, by J. Dudley McClain. Resurgens Publications, Inc., 1978. $13.95.

Political Profiles of White College Students in the South: Socio-Political Attitudes, Preferences, Personalities and Characteristics, by J. Dudley McClain. Richards House, 1977. $13.95.

Populism: Reaction or Reform, ed. by Theodore Saloutos. Robert E. Krieger Pub. Company, Inc., 1978. $4.50.

"Press Coverage of Louisiana's Shifting Role During the American Revolutionary Period, 1763-1783," by Elsie Mae Stallworth Hebert. Dissertation, University of Texas at Austin.

The Prodigal South Returns to Power, by Harry S. Dent. John Wiley and Sons, Inc., 1978. $12.95.

Red Eagle and the Wars with the Creek Indians of Alabama, by George C. Eggleston. AMS Press, 1977. Reprint of 1878 edition. $22.50.

Regional Growth and Decline in the United States: The Rise of the Sunbelt and the Decline of the Northeast, by Bernard L. Weinstein and Robert E. Firestone. Praeger Publications, 1978. $15.00.

"Revenue Growth and a State's Tax Structure: The Case of Louisiana," by Lloyd W. Shell. Dissertation. Louisiana State University.

Revisiting Blassingame's "The Slave Community": The Scholars Respond, ed. by Al Gilmore. Greenwood Press, Inc., 1978. $15.95.

The Rise and Fall of the Plantation South, by Rainardo Luaragli. Watts, Franklin, Inc., 1978. $10.00.

A Sacred Circle: The Dilemma of the Intellectual in the Old South, 1840-1860, by Drew G. Faust. Johns Hopkins Press, 1978. $11.00.

"A Social and Economic History of Columbia, South Carolina, During the Great Depression, 1929-1940," by Paul S. Lofton, Jr. Dissertation. University of Texas at Austin.

South Atlantic Urban Studies, Vol. 2, ed. by Jack R. Censer and N. Steven Steinert. University of South Carolina Press, 1978. $14.95.

The Southern Experience in the American Revolution, ed. by Jeffrey J. Crow and Larry E. Tise. University of North Carolina Press, 1978. $14.95.

"Sword and Plowshare: The Symbiotic Development of Fort Bliss and El Paso, Texas, 1849-1918," by Gaina L. Christian. Dissertation. Texas Tech University.

"Texas: Annexation to Secession," by Robert K. Peters. Dissertation. University of Texas at Austin.

"The United Mine Workers and the Demand for Coal: An Econometric Analysis of Union Behavior," by Henry S. Farber. Dissertation. Princeton University.

"Wealth Distribution in Colonial South Carolina," by William G. Bentley. Dissertation. Georgia State University.

Welfare in Rural Areas: The North Carolina-Iowa Income Maintenance Program, by John L. Palmer and Joseph A. Peckman. Brookings Institution, 1978. $11.95.

BIOGRAPHY AND AUTOBIOGRAPHY

Brother to a Dragonfly, by Will D. Campbell. Seabury Press, Inc., 1977. $9.95.

Children of Bladensfield, by Evelyn K. Ward. Viking Press, 1978. $14.95.

Hannis Taylor: The New Southerner as an American, by Tennant S. McWilliams. University of Alabama Press, 1978. $12.50.

"Herbert Hoover and Republican Patronage Politics in the South, 1928-1932," by David J. Ginzl. Dissertation. Syracuse University.

Jimmy Carter and American Fantasy, by Lloyd De Mause and Henry Ebel. Two Continents Publishing Group, 1977. $8.95.

Lawyer's Lawyer: The Life of John W. Davis, by William H. Harbaugh. Oxford University Press, 1978. $6.95.

Lucius Polk Brown and Progressive Food and Drug Control: Tennessee and New York City, 1908-1920, by Margaret R. Wolfe. Regents Press of Kansas, 1978. $12.50.

The Papers of Andrew Jackson, ed. by Sam B. Smith and Harriet C. Owsley. University of Tennessee Press. Date and price not set.

"The Randolphs of Turkey Island: A Prosopography of the First Three Generations, 1650-1806," by Gerald S. Cowden. Dissertation. College of William and Mary.

"A Rhetorical Analysis of Representative Gubernatorial Campaign Speeches by James Stephen Hogg (1890-1892)," by Carroll E. Hickey. Dissertation. Louisiana State University.

"A Rhetorical Biography of Walter Hines Page With Reference to His Ceremonial Speaking on Southern Education, 1891-1913," by Keith H. Griffin. Dissertation. Louisiana State University.

Selections from the Letters and Speeches of the Hon. James H. Hammond of South Carolina, compiled by William G. Simms. Reprint Co., 1978. Reprint of 1866 edition. $25.00.

Such as Us: Southern Voices of the Thirties, ed. by Tom E. Terrill and Jerrold Hirsch. University of North Carolina Press, 1978. $14.95.

"Ulrich Bonnell Phillips: His Life and Thought," by John H. Roper. Dissertation. University of North Carolina at Chapel Hill.

BLACK EXPERIENCES IN THE SOUTH

"Aesthetic and Ideological Radicalism of the 1930s: The Fiction of Richard Wright and Langston Hughes," by Mary E. Graham. Dissertation. Cornell University.

Black Culture and Black Consciousness: Afro-American Folk Thought from Slavery to Freedom, by Lawrence W. Levine. Oxford University Press, 1978. $4.95.

"Black Names in America: History and Meaning," by Murray Heller. Dissertation. Ohio State University.

"Blacks in Louisville, Kentucky, 1890-1930," by George C. Wright. Dissertation. Duke University.

Blues From the Delta, by William R. Ferris. Doubleday and Co., Inc., 1978. $8.95.

"A Broadcast Survey of Priority Needs in Baton Rouge, Louisiana, From the Perspective of Black Leaders and Public Representatives," by John N. England. Dissertation. Louisiana State University.

"Climbing the Racial Mountain: The Folk Element in the Works of Three Black Writers," by Gordon Q. Freeman. Dissertation. University of New Mexico.

"Ethiopia in Babylon: Antebellum American Romanticism and the Emergence of Black Literary Nationalism, " by John S. Wright. Dissertation. University of Minnesota.

The Fight Against Slavery, by Terence Brady and Evan Jones. W.W. Norton and Co., Inc., 1977. $7.95.

"The First Shall Be Last: A Study of the Pattern of Confrontation Between Old and Young in the Afro-American Novel," by John T. Reilly. Dissertation. Cornell University.

From the Grassroots: Black Political Essays, by Manning Marable. Challenge Press, 1978. $11.00.

God of the Oppressed, by James Cone. Seabury Press, 1978. $3.95.

Historical Research Respecting the Opinion of the Founders of the Republic on Negroes as Slaves, as Citizens, and as Soldiers, by George Livermore. Augustus M. Kelley, Pubs., 1978. Reprint of 1863 edition. $6.25.

In Search of Buddy Bolden: First Man of Jazz, by Donald M. Marquis. Louisiana State University Press, 1978. $9.95.

"Iron Ore Miners and Mine Mill in Alabama: 1933-1952," by Horace Huntley. Dissertation. University of Pittsburgh.

James T. Rapier and Reconstruction, by Loren Schweninger. University of Chicago Press, 1978. Price not set.

"The Life Story of the Blues Musician: An Analysis of the Traditions of Oral Self-Portrayal," by Barry L. Pearson. Dissertation. Indiana University.

"The Measurement and Significance of Racial Residential Barriers in Atlanta, 1890-1970," by Michael J. O'Connor. Dissertation. University of Georgia.

" 'Off-guard': The National Guard and Race-Related Civil Disturbances in the 1950s," by William R. Wachs. Dissertation. University of North Carolina at Chapel Hill.

"Power in the Black Subcommunity of Orlando," by John T. Washington. Dissertation. University of Florida.

"The Role of Shape-Note Singing in the Musical Culture of Black Communities in Southeast Alabama," by Doris J. Dyen. Dissertation. University of Illinois at Urbana-Champaign.

The United States and the African Slave Trade, 1619-1892, by Peter Duignan and Clarence Clendenen. Greenwood Press, Inc., 1978. Reprint of 1963 edition. $11.00.

"The Use of Black American Slave Folk Songs in the Social Studies Curriculum," by Andrew M. Pickett, Jr. Dissertation. University of Illinois at Urbana-Champaign.

The Wheel of Servitude: Black Forced

Labor After Slavery, by David Novak. University Press of Kentucky, 1978. $9.50.

" 'Then My Living Will Not Be In Vain': A Rhetorical Study of Dr. Martin Luther King, Jr., and the Southern Christian Leadership Conference in the Mobilization for Collective Action Toward Nonviolent Means to Integration, 1954-1964," by Rose M. Sloan. Dissertation. Ohio State University.

EDUCATION

"An Analysis of Legislation and Court Decisions Affecting Public School Teachers and Students in Kentucky," by James E. Carver. Dissertation. Indiana University.

"Centralization of Administration in Higher Public Education in Alabama: A Study of the Impact of Politics on Governance," by Malcolm Portera. Dissertation. University of Alabama.

"The Common School Movement in the South, 1840-1860," by Kathryn A. Pippin. Dissertation. University of North Carolina at Chapel Hill.

"A Comparison of Black and White Institutions of Higher Education in North Carolina," by Cleo F. Thompson, Jr. Dissertation. Duke University.

"Desegregating Private Southern Schools, A Southern Example," by John B. Williams III. Dissertation. Harvard University.

"The Development of Educational Media in Louisiana, 1908-1976," by Aneta Pauline M. Rankin. Dissertation. Louisiana State University.

"Explanations of Public Policy: Environment and Power in Public Education Policy in Georgia, 1930-1970," by Peggy H. Dubose. Dissertation. Vanderbilt University.

"Exploring the Potential for Treatment of Economic Illiteracy in South Florida," by Dorothy A. Dunn. Dissertation. University of Miami.

"A History of the Louisiana School Boards Association," by Anthony E. Pacella. Dissertation. Louisiana State University.

Jackson State University: The First Hundred Years, by Lelia G. Rhodes. University Press of Mississippi, 1978. Price not set.

A Profile of Higher Education in the South in 1985. Southern Regional Education Board, date not set. $1.50.

"The Relationship of Teacher Morale to the Racial Composition of the Student Bodies in Selected Elementary Schools in Metropolitan Atlanta," by Charles H. Henderson, Jr. Dissertation. Mississippi State University.

"Second Generation Discrimination: Unequal Educational Opportunity in Desegregated Southern Schools," by Joseph E. Stewart, Jr. Dissertation. University of Houston.

"A Status Survey of Texas' Bilingual - Bicultural Education Programs," by Jesus E. Zamora. Dissertation. University of Texas at Austin.

"A Study of Black Studies in the Social Sciences and Humanities Curricula of Ten Colleges and Universities in Arkansas," by Qumare A. Morehead. Dissertation. Kansas State University.

"A Study of the Working Relationships Between the Arlington County, Virginia, School Board and the Arlington Education Association from 1966 to 1976," by James P. Kacsmarik. Dissertation. George Washington University.

CULTURAL PERSPECTIVES

Appalachia on Our Mind: The Southern Mountains and Mountaineers in the American Consciousness, 1870 - 1920, by Henry D. Shapiro. University of North Carolina Press, 1978. $15.95.

The Art of Southeastern Indians, by Shirley Glubok. MacMillan Publishing Co., Inc., 1978. $7.95.

"Baptized in Blood: Southern Religion and the Cult of the Lost Cause, 1865-1920," by Charles R. Wilson. Dissertation. University of Texas at Austin.

Christian Occasions: A Country Music Magazine Press Book, by Allan Whitman. Doubleday & Co., Inc., 1978. $6.95.

The Church that Produced a President: The Remarkable Spiritual Roots of Jimmy Carter, by James and Marti Hefley. Weden Books, 1978. $10.95.

Clarksville Architecture, by John Halliburton. John Halliburton Press, 1978. $15.95.

Country Music by Thomas A Hill. Watts, Franklin Inc., 1978. $4.90.

The Country Music Quiz Book, by Don Humphreys. Doubleday & Co., Inc., 1978. $3.95.

Early Architecture of Charleston, by Albert Simons and Samuel L. Lapham. University of South Carolina Press, 1978. Price not set.

"The Early Architecture of New Bern, North Carolina, 1750 - 1850," by Lynda V. Herzog. Dissertation. University of California, Los Angeles.

The History of Country Music, by Robert K. Krishef. Lerner Publications, 1978. $4.95.

"The Irish Travellers of Georgia," by Jared V. Harper. Dissertation. University of Georgia.

"Louisiana French: A Linguistic Study with Descriptive Analysis of Lafourche Dialect," by Larbi Oukada. Dissertation. Louisiana State University.

Media-Made Dixie: The South in the American Imagination, by Jack T. Kirby. Louisiana State University Press, 1978. $9.95.

The Parish Court Houses of Louisiana, by Betty L. Morrison. Her Publishing Co., 1978. $20.00.

People of Plains, Georgia, by Steven Borns. McGraw-Hill Book Co., 1978. $6.95.

The Sacred Harp: A Tradition and Its Music, by Buell E. Cobb, Jr. University of Georgia Press, 1978. $10.00.

The Story of the Carter Family, by Stacy Harris. Lerner Publications, 1978. $4.95.

Sunbelt Retirement: The Complete State-by-State Guide to Retiring in the South and West of the US, by Peter A. Dickinson. E.P. Dutton & Co., Inc., 1978. $10.95.

Texas Log Buildings: A Folk Architecture, by Terry G. Jordan. University of Texas Press, 1978. $15.95.

True Grits...Everything You Want to Know About Southern Cooking, by Sam C. Rawls and Rosa Tusa. Bantam Books, Inc., 1977. $1.25.

Western Stars of Country Music, by Robert Krishef and Bonnie Lake. Lerner Publications, 1978. $4.95.

LITERATURE

"The American Pro-Slavery Novel: A Study in the Popular Fiction of the 1850s," by Katherine E. Staples. Dissertation. University of Texas at Austin.

"A Bibliographical Study of George Washington Cable and a Checklist of Criticism, 1870-1970," by Cason L. Hill. Dissertation, University of Georgia.

"Constance Cary Harrison: American Woman of Letters, 1843-1920," by Sherrolyn Maxwell. Dissertation. University of North Carolina at Chapel Hill.

"Flannery O'Connor's American Models," by Margaret L. Marks. Dissertation. Duke University.

"The French and Faulkner: The Reception of William Faulkner's Writing in France and Its Influence on Modern French Literature," by Phiet Q. Tran. Dissertation. University of Texas at Austin.

A Glossary of Faulkner's South, by Calvin S. Brown. Yale University Press, 1978. $3.95.

"A History of McCauley's Theatre, Louisville, Kentucky, 1873-1925," by Don W. Combs. Dissertation. University of Illinois at Urbana-Champaign.

"Humanistic and Legal Values in Some Works of Faulkner," by Ralph E. Millis. Dissertation. University of Iowa.

"John Donald Wade: A Critical Biography," by Gerald J. Smith, Jr. Dissertation. University of Georgia.

"Look A-Yonder, I See Sunday: A Critical Study of the Novels of Bernard Cheney," by William I. Beauchamp, Jr. Dissertation. Emory University.

Mark Twain Speaks for Himself, ed. by Paul Fatout. Purdue University Press, 1978. $8.50.

"The Poetry and Poetics of Henry Timrod, Paul Hamilton Hayne, and Sidney Lanier: An Essay on Art and Community in the Nineteenth Century South," by James R. Loney. Dissertation. University of Georgia.

"**Pylon**: The Doomed Quest. A Critical and Textual Study of William Faulkner's Neglected Allegory," by Helen M. Barthelme. Dissertation. University of Texas at Austin.

"Salt of the Earth: Plain People in the Novels of Bernice Kelly Harris," by Erma W. Glover. Dissertation. University of North Carolina at Chapel Hill.

The South and Faulkner's Yoknapatawpha, ed. by Evans Harrington and Ann. J. Abadier. University Press of Mississippi. Date and price not set.

"The South in Motley: A Study of the Fool Tradition in Selected Works by Faulkner, McCullers, and O'Connor," by Joy F. Shaw. Dissertation. University of Virginia.

"The Theme of Community in Twentieth Century Southern Novels," by Deborah S. Kolb. Dissertation. University of North Carolina at Chapel Hill.

"Thomas Wolfe's Characters and the Search for Certitude," by Robert A. Fink. Dissertation. Texas Tech University.

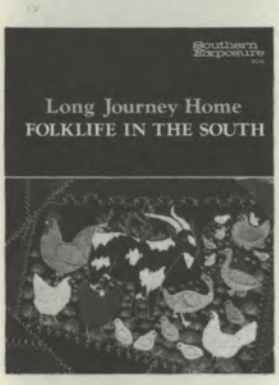
"Warren the Novelist," by Robert P. Haynes. Dissertation. University of Illinois at Urbana - Champaign.

"William Faulkner's Compleat Woman," by Mary Ellen Marshall Goddenberger. Dissertation. University of Nebraska at Lincoln.

"William Gilmore Simms: Fictionist as Military Historian of the Revolution," by William G. Belser, Jr. Dissertation. St. John's University.

FROM THE PAGES OF

Southern Exposure



- Who's Getting Rich in the New South
- Birth of the Sit-in Movement
- The Coca-Cola Story: Journey to the White House
- The Great Hookworm Campaign
- Being Southern Baptist on the Northern Fringe
- Miss Gussie: Midwife from Plains, Ga.
- Fifty Years of "Bloody" Harlan County
- A Return Visit with James Agee's "Emma"
- Who Owns the South's Media
- Living Off the Sea: The Culture of Coastal Fishing Villages
- Origins of the Grand Ole Opry
- The Scandal of the Second-Home Developers
- Joan Little's Own Story
- Piper Davis and the Negro Baseball League
- In Appalachia, Millionaires & Mobile Homes
- The Voices of Beale Street
- Magnolias Grow in Dirt: The Southern Belle's Bawdy Humor
- The State of Black Politics
- Billy Graham, Superstar
- The Southern Tenant Farmers Union
- Sallie Mae Hadnott: Grass-roots Organizing in Alabama
- Growing Up Gay in Dixie
- The South's Biggest Defense Contractors
- Still Fighting the Klan in Mississippi
- Textile Women: Three Generations In the Mill
- Hog Heaven: Barbecue in the South
- Tracking the Lost String Bands
- The South's Right-Wing Senators
- Louisiana's Angola Prison Plantation
- From Delta Blues to Dixie Rock
- A Mighty Fortress: Power and Wealth in the Southern Church
- The Children Who Integrated the South's Schools – 25 Years After *Brown*
- Georgia's Radioactive Wasteland
- People's Medicine in the Early South
- Agribusiness and the Loss of Black-Owned Land

All back issues of ***Southern Exposure*** *are still available. Write us for a descriptive brochure, or send $10 for a year's subscription (four issues) to P.O. Box 531, Durham, North Carolina 27702*