

# A PATH WELL TAKEN: REFLECTIONS ON SOCIAL WORK IN OCCUPATIONAL HEALTH

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*In this narrative, the author shares reflections on her work with other disciplines in the field of occupational health and safety, beginning over 30 years ago in the context of an academic medical center. She describes social and economic realities shaping the "beginnings" of a program designed to address the impact of occupational hazards on workers and families. She discusses the nature of services that developed over the course of the program's development and reflects on her actions as a member of the multidisciplinary team during a memorable episode in the program's history. Additionally, the author discusses the complexities involved in determining a course of action when one's views conflict with other team members, and the ethical issues that may arise in the use of a publicly-sanctioned authority on behalf of a population at risk.*

## Introduction

A little more than 30 years ago, I stood with others outside a large medical center on the occasion of a ground-breaking ceremony for a new hospital wing. I remember the day well. I was a relatively newly-minted M.S.W., just two years out from graduate school where I had majored in "The World of Work" and less than one year into my role as a medical social worker. This was a time of expansion in academic medical centers around the country. Carter was still in office and funds had been allocated for medical student and physician training, including in the area of occupational medicine.

The hospital expansion carried much significance for the surrounding community; among other things it heralded the promise of new jobs, and organized labor was out in force for the groundbreaking. Owing to personal connections and a general interest in labor, I had made the acquaintance of staff from several unions and I stood among them in the large crowd that had amassed for the ceremony.

"Did you hear?" The local president from the state's largest industrial union was speaking with a health care union rep. "They're going to start up an occupational health clinic."

My ears perked up! I asked a few questions and learned the name of the physician who would be heading up this effort. No sooner had the ceremony ended than I had contacted him by phone and arranged a

meeting time to discuss the role that social work might play in this new venture.

As I look back on this eventful day, I realize that I was propelled forward by a strong belief in the importance of worker health, the skills and values that social work uniquely lent to this field, and the rich possibilities for productive work that lay ahead. While I was learning a great deal as a medical social worker, I longed for an opportunity to be engaged in work that was closely connected to the workplace: my ongoing passion.

I couldn't have known that I was about to embark on a journey lasting more than 18 years and providing a richness in practice experience beyond what I could have imagined. My learning began with meeting individuals whose work lives had ended abruptly, sometimes in their 30s or 40s. The devastating effects of job loss and work-related disability had eroded their health, self-confidence, and means of livelihood in many cases never to be regained. I was introduced to the complexities of interdisciplinary teamwork in the context of an institution characterized by long-standing hierarchical relationships. I gained an appreciation for the groups, organizations, science, and laws comprising the field of occupational health and safety and the continuous interplay of these elements in efforts to bring about change. My learning continues in reflecting on a memorable piece of practice at a time when social work was forging a path alongside other professions



in the development of a new model of occupational health care practice.

While working in the field of occupational health and safety, I obtained my doctorate and went on to teach social work and direct a program serving vulnerable populations. In the forthcoming narrative, I return to a time and place in my professional experience that—while removed from my daily thoughts more than two decades hence—continues to have a profound impact on my practice today.

### **Beginnings of the Program: The Social Context of the Work**

From the standpoint of occupational health and safety, this was a very different era from the one that exists today. Jimmy Carter had been elected President just two years earlier and had appointed Eula Bingham as head of OSHA. An occupational health scientist, Bingham called for “an all out effort to combat occupational illnesses and disease” (United States Department of Labor [USDOL], n.d.). The new energy infusing the occupational safety and health movement as a result of Bingham’s pro-worker stance unfortunately foreshadowed the backlash that followed on the part of business interests throughout the Carter administration, culminating with the resignation of Bingham and the nomination by Ronald Reagan of Thorne Auchter, the Vice President of a construction firm, in 1981.

In the decade immediately preceding the passage of OSHA, labor had begun to shift its own focus from a traditional emphasis on-the-job safety (i.e., protection against injuries) to dealing with the long-term health effects of occupational hazards (Early, 2008). The “New Directions” grant program had just been established to provide seed money to other organizations to develop and offer training to employers and employees about workplace hazards and their legal rights.

Coalitions for Occupational Safety and Health (COSH) had already been in existence around the country beginning in 1972. The COSH groups had played a prominent role since the passage of OSHA supporting union locals’ health and safety work, including safety training and community organizing. Although I hadn’t been actively involved with them, I

had known people who had during and following my undergraduate years. The occupational health and safety “cause” held much attraction for young, progressive professionals and graduate students including nurses, industrial hygienists, physicians, and community activists; it was seen as an opportunity to join with workers and labor unions in the industrial sector in the struggle for healthy workplaces. The group that rallied around the fledgling clinic reflected this perspective and constituted more of a “collective” than a program staff. As whatever start-up funds were then available did not support salaries, most people associated with the new venture worked on a volunteer basis. Some, like me, had other full-time jobs and added voluntary hours to their work day to help out in the clinic. Others were students in the university-medical center complex; still others were neither employed or attending school but were determined nonetheless to add their influence to the beginnings of a new program.

The feeling of camaraderie among the participants—mostly late 20s, early 30-somethings—was unmistakable. The “office” was literally a small closet that had been converted into a work space located in the primary care center; everyone managed to pile in. Characterized by alliances primarily among non-medical groups and organizations in which labor held considerable sway, the occupational health movement exercised a powerful effect over the clinic’s “team” concept in the beginning; physician dominance, true of the surrounding medical establishment, was repeatedly and openly called into question by all involved. However, it was the physicians who authored the grants that would provide the basis for funding a future program.

### **Incorporating the “Activist” in the “Professional”: A New Perspective**

Those drawn to the clinic brought with them the fervor of volunteers in a political organizing campaign. While my own attraction to a social work concentration in the workplace had held similar meaning, I now began to view my work from the vantage point of a professional, rather than volunteer activist.



During this time, I can recall numerous three- and four-hour long meetings, often held in people's homes, in which the future of the program was discussed with great intensity. In these early meetings, the question as to whether the program would provide a clinical service rather than advocacy alone was the main point of contention. At the time, I don't think I fully grasped that the program's real chance for survival probably lay in developing its clinical function as a training ground for physicians. What I did know was that the provision of services for workers and their representatives was a necessary first step in establishing the program. Following the principle that directed the medical social worker to enable the patient to make the best use of what the physician has to offer (Cockerill, 1950), I conceived of my role as strengthening and making available to workers and labor the resources that the medical setting had to offer. In the seemingly endless meetings, I took the position of supporting the efforts of the physician who had begun taking the necessary steps to establish the clinic as a legitimate program in the department of internal medicine.

While I viewed my perspective as one of forwarding the struggle for health and safety in the workplace, others—arguing against a clinical model—felt that I had been co-opted by the status quo, or that I “identified with the physician.” Since I felt secure in my purpose, their criticism did not deter me. In my view, their position risked the loss of the entire venture, since whatever activism we may have envisioned for the program, it had been conceived in the context of an academic medical setting. As Hyman Weiner put it “...an interdisciplinary group doesn't transcend boundaries of the institutional setting” (Weiner, n.d., p. 8).

Looking back now on my view of the social worker's role on the team, I may have missed an opportunity to develop a more collaborative approach toward a shared vision of the program with other group members. Although the group's objective in this case may have differed somewhat from the provision of traditional health care (the context for Weiner's discussion), still the overarching issue he

addresses—the dynamics of inter-professional communication—is the same. Weiner writes:

*“Although social workers feel that they have limited power, they also have a sense of omnipotence and really believe their job is to straighten out the hospital.... Who appointed us as the social conscience?”* (Weiner, p. 4)

### The Economic Context

In the late 1970s, steel factories began closing. A recent study looking at the decline in injury and illness rates since the late 1970s and early 1980s attributes approximately 18% of the decline to a shift in employment from more hazardous to less hazardous industries. According to this study, shifts in manufacturing sub-sectors accounted for an additional 5.7% of the decline (Morse, Deloreto, St. Louis, & Meyer, 2009). This shift from manufacturing to service jobs in the 1970s and 1980s was most acutely felt by residents of large industrial cities in the Northeast and Midwest (Bound & Holzer, 1993). With the loss of manufacturing jobs, union membership began to decline in the United States. The percent of workers age 16 and older who were members of a union or an employee association similar to a union (12%) in 2007 represents a decline of 8 percentage points in union membership since 1983 (Freeman, 2007).

Many workers who came to the clinic at the start of the program were being laid off from the heavy industries, mainly steel. They had come (often referred by their union) to obtain evaluation and treatment for health problems they had been experiencing and to learn whether these problems were a result of exposures to lead and silica dust. The latter service was critical, as a work-related diagnosis was necessary in order to apply for compensation. In addition to the loss of physical health, impeding a move into alternative employment, workers in manufacturing at this time often lacked the post-secondary education and technical skills needed for comparably paid work in the non-industrial sector (Workforce Alliance, n.d.). Years later, some of the early patients were able to obtain



low wage employment in health care and other expanding sectors; these jobs were a far cry from the “well-paid, unionized industrial jobs that had disappeared” (Olson, 2005).

### Learning from the Past: Re-integrating the Social Work Role in Occupational Health

I became interested in the intertwining roots of social work, industrial hygiene, and occupational medicine in the context of Hull House and the settlement house movement in the early part of the 20th century. I sought to convey this history to social work colleagues as well as to other disciplines on the occupational health care team. From the investigatory work of the social survey movement documenting the unmet needs of workplace injury victims, to the subsequent enactment of workmen's compensation, to the work of Grace Burnham, Harriet Silverman, and Charlotte Todes Stern (who founded the Workers' Health Bureau of America in the 1920s), the social work profession had played a significant role in highlighting the impact of workplace hazards on workers and their families and advocating for services and preventive strategies on their behalf (Eastman, 1910; Kellogg, 1914; Rosner & Markowitz, 1987). Looking over notes from a lecture I had given during this time, I am struck by the power of a quote I had included by Frances Perkins. Perkins trained as a social worker and witnessed the Triangle Shirtwaist Factory Fire in 1911, in which 147 women and men were killed trying to escape the factory; the actual building structure itself received minimal damage (Perkins, 1921):

*“Never shall I forget that cold sinking feeling at the pit of my stomach as I watched those girls clinging to life on the window ledge until, their clothing in flames, they leaped to their death from the ninth floor of that loft building.”*

Over the next eight years, while continuing as a member of the hospital social work department, I threw myself into all aspects of

practice, advocacy, and education in the area of occupational health and safety. Others had already begun to develop the social work role in this arena (Shanker, 1983), and our mutual work in similar settings served as an additional source of support and professional growth. The work involved a range of practice modalities. In the early 1980s, there were advocacy meetings supporting the passage of plant closing legislation as well as opportunities to present in diverse settings ranging from the medical school to the AFL-CIO-sponsored community services series. Joint work with educators in the labor movement led to work with a support group for striking workers and an opportunity to serve as group leader on an occupational health and safety tour to the Soviet Union. We also carried out a study looking at outcomes for injured workers who had applied for workers' compensation (Lewis & Mama, 1987). I recall a colleague teaching in a school of social work noting that the work in the clinic provided an example of “generalist practice,” an approach that was being widely introduced to foundation social work curriculum at the time.

The following excerpt from an article written during this period captures the range of services provided:

*“The work of the early reformers continues to serve as a model for practice with an ever-changing workforce; accordingly, a range of direct service modalities—including psychosocial assessment and evaluation at intake, ongoing individual and family casework, and therapeutic and psycho educational group treatment (both individual and multi-family in membership)—have been developed in the context of the author's work as a member of an interdisciplinary team of health and safety professionals. Community organizational efforts aimed at developing self-help and advocacy groups for the work-injured and disabled have also been utilized, along with outreach*



*and education to the labor and industrial community and its social service network contributing to the expansion of clinic services to meet identified needs of the industrial community"* (Lewis, 1989, p. 100).

### **The Efficacy of the Small Group**

By 1987, the Occupational Health Clinic had been in operation some eight to nine years. Over 4000 patients had been seen at the program's two clinical settings (a satellite clinic had been located near a large industrial site). According to my contemporary account:

*"Patients were referred from a variety of sources, including employers, labor organizations, lawyers, other physicians, and through media promotion and word-of-mouth. Diseases of the lung (asbestosis, asthma, and others) were among the most frequent occupational diseases seen in the clinic. Symptoms due to exposures to lead, organic solvents, and heavy metals are a second common category of problems. Psychiatric sequelae of workplace exposures and injuries are evaluated and referred for treatment"* (Lewis, 1993, p. 22-23).

My notes from this period included pages of facts about occupational exposures, the history of occupational medicine, and the nature and treatment of post traumatic stress disorder. They illustrate the extent to which other members of the interdisciplinary team contributed to my professional growth during this time. In addition to medicine and industrial hygiene, psychiatry and psychology, also interested in contributing to and learning from interdisciplinary work in this setting, had become actively involved in the program. In particular, family intervention—still a burgeoning practice modality at this time—offered rich opportunities for interdisciplinary practice, with each of the disciplines offering different expertise and interests.

In addition to working with individuals and families, I led a series of groups for workers, the first being an educational/informational group with an open enrollment. Among other issues, the group had touched on the frustration members experienced coping with illness while dealing with the compensation system. A quote from an influential author and pioneer in group work is worth remembering today (Schwartz, 1986, p. 24):

*"The group workers' experience told them that there was something in the nature of doing, and particularly collective doing, that helped people find new ways of looking at themselves and the world around them."*

About 10 individuals and families from this larger group requested continuing assistance in the form of a more intensive support group. A multi-family psychoeducational group for recently diagnosed occupational disease patients was thus conceived by a doctoral-level psychology student whose interest was stress in the workplace. The criteria for group membership included that they be a clinic patient/family member, that their presenting complaint had been diagnosed as having a workplace etiology, and that the onset of their complaint/illness had occurred within six months prior to admission to the group. Initial group members included manufacturing, steel, and building trade workers with diseases related to long-term exposures to lead, asbestos, and silica dust. The group ranged from those with significant impairment who had continued to work, to those with mild impairment who had been unable to continue working and had become socially withdrawn. This smaller group dealt with members' personal experiences: anger regarding their experience with employers' lack of responsiveness and failure to assume responsibility for the hazards that had led to their health problems, fears associated with work including re-exposure and physical impairment, and family issues including "role reversal" with wives taking on the role of main breadwinner. Members benefitted from



sharing with others, which added to their self-esteem. Some patients utilized the group to gain support for enrolling in vocational rehabilitation, a route previously rejected due to feelings of hopelessness.

The psychology student served as group co-leader, imparting much in the way of knowledge and skills in group dynamics. Upon reflection, the male/female co-leadership also played a supportive role for group members, most of whom were male workers and their wives. The multi-family short-term group ran for several years with a changing membership; each incarnation of the group reflected the varying perspectives and emphases of psychiatrists who later served in co-leadership roles.

One the early attendees of the group had worked in a chemical plant for many years and had developed a serious lung disease that left him with a permanently disabled while still in his 30s. Two or three years after attending the group he enrolled in a human services program at the local community college, choosing to carry out a semester-long internship at the clinic. The opportunity to work with him in the role of supervisor was, and remains, one of the highpoints of my career. His assignment involved organizing an advocacy event with the local COSH group. In a file from this period, I saved a letter from the COSH director congratulating him on the fine job he had done, and inviting him to become a member of a newly-formed coordinating committee for a local labor council health and safety initiative. Also in this file is a signed invitation to his graduation, a powerful reminder not only of human fortitude but of the learning we gained, as professional staff, from those who made use of our services during this time. In her book about social work services in the National Maritime Union in the early 1940s, Bertha Reynolds reflected on the learning available to professionals working in membership organizations:

*"Proximity to people working on their own problems in such well-planned ways could not but enhance a caseworker's faith in the capacity of ordinary people to do*

*a better job for themselves than anyone outside their situation could do for them" (Reynolds, 1951, p. 10).*

### **A Multidisciplinary Team Struggles with an Ethical Dilemma**

Two questions—generic to practice in a number of settings—can be distilled from the following reflection on a memorable piece of practice during this time:

*What does a social worker do if she feels strongly that something other than what the team has determined to be the correct approach should be done?*

*When and in what circumstances does one make use of the public sanctioned authority, however flawed its protective capacity?*

After nearly eight years of practice in the occupational health clinic I encountered a situation which, while not completely unfamiliar, was nevertheless cause for a feeling of uncertainty which signaled a need to reach beyond practice tools which were usually readily at hand. First one, then more workers from a local fabric-coating plant (eventually totaling 37) were diagnosed with liver-function abnormalities; 10 of these had toxic hepatitis caused by exposure to chemicals in the poorly ventilated plant. None of them spoke English.

Familiar were the identifying characteristics of the presenting problem: a 38 year-old worker who had moved to Connecticut from Puerto Rico with his family, presenting to the clinic with a debilitating illness caused by exposures in the workplace. Familiar was the economic backdrop to this worker's plight; with few vocational opportunities on the island, he had taken a job in an unorganized shop employing mainly Spanish-speaking immigrants from Central and South America. Familiar also was the response on the part of the employer: only after the physician provided convincing evidence of the workplace etiology of toxic hepatitis which had



afflicted almost one-third of the workforce (and probably many of those who had already left) would the employer give permission to the clinic's industrial hygienist to inspect and make recommendations for changes in the workplace. Familiar as well was the insurance carrier's decision to contest the workers' claims for compensation on the basis of cause despite the employer's implementation of recommended changes to the work processes that were felt to be contributing to a toxic hepatitis epidemic. Familiar finally was the broader context of social injustice characterized by racism and exploitation giving rise to and perpetuating such conditions in the first place.

Somewhat less familiar was my perception of the wide gap between the set of practice principles to which I, as the social worker, looked as a guide to intervention and those of the other disciplines (medicine, industrial hygiene) on the team, since there was usually mutual agreement among team members. The other team members had decided to work in concert with the employer in an attempt to forego a lengthy delay in government response (and the potential for ultimate inaction) that was felt almost certainly to occur had the team decided to notify OSHA of the problem. The decision to work in concert with an employer who had disregarded recommendations by federal authorities to correct health standard violations in the past seemed to me a risky proposition.

While physicians provided medical treatment and advice to individual patients—including recommending removal from the workplace—and the industrial hygienist provided guidance to the employer on structural changes in the work process, the company continued production and the number of workers showing signs of illness increased, rather than decreased. The physicians then recommended that the company shut down production until the situation could be remedied, threatening to contact OSHA if they did not comply. Only when this threat was leveled did the employer agree to the physicians' recommendations. In addition, the physicians also notified the Board of Health that a toxic hepatitis epidemic had been uncovered; this

agency also had the authority to shut down the plant if necessary. While the physicians recognized that the "threat" of contacting OSHA was a powerful motivator in the company's decision to comply with their recommendations, they also viewed the possibility of leaving a response to the outbreak in the hands of OSHA as unacceptable.

In the meantime, there had been no effort to involve the workers in a decision-making process, especially as they were without any elected representation. In the absence of a contractual agreement between workers and management, those who had not filed workers' compensation claims (but who were ordered to stop working in the jobs in which they were likely to be further exposed to harmful chemicals) were either being laid off or, in an effort to avoid the economically unfeasible alternative, were electing to continue working. So while the clinic attempted to work with the employer to contain the outbreak and bring about the necessary changes, the conditions of work—outside the jurisdiction of the clinic—continued under the control of the employer. In fact, had an OSHA inspection taken place, the rights of the workers to compensation during the period in which they were removed might have been better assured, due to the provisions of the Act.<sup>1</sup>

As a general rule in practice, I knew to access available resources for clients if their circumstances warranted them, and if they agreed to such a plan. However, the decision of the other team members to circumvent an OSHA complaint and work cooperatively with the employer to protect workers from further exposure while their claims for compensation were being denied resulted in the creation of major impediments to the implementation of this rule. I felt the workers needed more help than we were providing.

A decision to withhold information about filing an OSHA complaint as a resource for workers is an example of paternalism, wherein decisions are made on the client's behalf in order to protect him. While the conscious withholding of information is the same as lying, there may be circumstances where lying is necessary. On what ethical grounds were we to withhold information from the client(s) that



would have permitted their making well-informed choices? Lewis's article on "Ethical Assessment" (Lewis, 1984) discusses the issues involved in following a principle of maximizing a person's participation in decisions that affect him or her, if doing so may lead to the undesirable consequence of presenting a further threat to his or her well-being. In such circumstances, Lewis explains, "a series of logical steps must be followed in assessing the ethics of the situation to see what conclusions would be reached for further action" (p.209). Applying this analysis to this situation, the decision to withhold information from clients concerning their rights with regard to accessing OSHA resources should have prevailed only if it was clear that the threat to the clients' well-being in providing such information was sufficient to warrant sacrificing their freedom of choice. Since the company's compliance with the clinic had not yet yielded a level of well-being for workers that exceeded that which had existed before, and since the health of more workers was in fact worsening, then the possible consequence of company non-compliance or OSHA non-responsiveness was not sufficient enough threat to the clients' well-being (already compromised) to warrant sacrificing their freedom to choose an alternate strategy. In such a case, the client's rights "would be given precedence over what is thought to be for his own good" (Lewis, 1984, p. 210).

#### **The Role of Students in the Agency: Catalysts for Change**

Two MSW students carrying out their field placements in the clinic (both students of color) questioned me privately as to whether the physicians would have made the same decision if the workers were white and English-speaking. One voiced discomfort over her perception of the team's decision to withhold information as hinging on the workers uninformed status regarding their rights, the language barrier, and their fears associated with their immigrant status. The students wondered what rationale we would offer if the workers later learned of the right to contact OSHA, and asked why, if we had known of this option, had we not informed them? The

justification for keeping this information from them could only be that by doing so their health and well-being was protected beyond what would have been the case had they been informed.

#### **Utilizing Labor's Involvement: The Labor Advisory Committee**

The students had been assigned to convene the next Labor Advisory Committee meeting. I had organized the Committee some four years earlier, beginning with outreach to the member unions of the state AFL-CIO, speaking at monthly meetings of several of the 16 central labor councils state-wide and gauging their interest in such a committee.

The purpose of the committee was to review and ensure labor input into the program's outreach, education, and clinical services as well as to provide education regarding the health and safety priorities of the attending unions' membership. The Committee met quarterly with a core membership of 15; at its height, the Committee had a mailing list of 40 individuals representing labor unions, labor educational programs, and the social service program of the AFL-CIO, activist organizations/COSH groups, and representatives from the offices of elected officials. All clinic staff attended, and staff as well as labor participants and invited speakers presented on topics of interest at each meeting. Given the breadth of its membership, the Committee was able to grapple with issues forming the larger social context of occupational health care. A year earlier, in 1986, the Committee had hosted a presentation from a leader of the effort in Massachusetts to carry a ballot question about a national health program—the first state in the country to do this—and a leader of a coalition working to pass the National Health Services Act which had been introduced annually since 1975 by Ron Dellums, Democrat of California. Now, reading through an article that appeared in the local newspaper at the time about that meeting brings into sharp focus the years of struggle for universal health care that have led up to our current impasse (Barbuto, 1986)<sup>2</sup>. Sometime later, participation began to dwindle and the Committee ended. By this time, most



of the unions were familiar with the work of the clinic and were actively working on issues within their local; the original purpose of the group no longer held the salience that it had for either the clinic staff or the participants. However, when the program faced loss of funding from the hospital in the late 80s- early 90s, many members of the group were quickly activated to support state legislation to fund a statewide network of occupational health clinics.

Based on their experience in the clinic, the students had decided to focus the upcoming Committee meeting on the issue of minority workers' occupational health risks. Earlier they had expressed concerns that the population seen in the clinic was overwhelmingly white, reflecting the demographics of the unionized workforce. The students reasoned that this did not make sense, since workers of color were at higher risk. Minutes from this meeting (April, 1987) indicate that the students presented statistics including a 20% higher disability rate among workers of color compared to whites, and led a discussion on the barriers to accessing clinic services for minority workers in hazardous jobs and work settings.

Meanwhile, I had begun pursuing a plan that the team had agreed upon, which was exploring other community resources that might be available for the workers. A local multi-service agency serving a mainly Latino population had indicated that while they did not have the resources to help address the workplace problem, the workers could present for help with referrals to entitlement, housing, or employment programs. An agency in another part of the state with which I had developed strong ties (a large health care council whose mission was to improve the health of the Latino community) indicated that while they couldn't offer direct help, they had just been visited the previous day from a union organizer who had visited them specifically hoping to learn about workplaces employing Latino workers in which workplace health, and other working conditions, were problematic. They suggested I contact him and gave me his number.

I knew that any involvement with an organizer might signal the end of the clinic's private collaboration with the employer. I

thought about how to approach the situation: I was not interested in undermining the clinic's efforts, but felt that making contact with the organizer would be important.<sup>3</sup> I thought about the upcoming Labor Advisory Committee meeting that would focus on minority workers and felt that this organizer's involvement could be beneficial to the Committee as well as to other workers at risk. I decided to contact him and invite him to the next meeting which was to take place the following month. The Labor Advisory Committee, created years earlier, proved to be a vehicle through which to incorporate his involvement.

The organizer of course wanted to know something about the clinic's experience with minority workers; I talked in general about our experience in this area. He asked whether he might be able to speak with any of the workers we were currently seeing. I explained that I could not share this information, but offered to talk with the physician to see whether s(he) felt it would be helpful to provide his name to the workers; if the physician agreed and the workers were interested, they could contact him. In the meantime, the organizer indicated that he would come to the next Committee meeting and we would meet then.

### **Paving a Path for Worker Involvement**

I then went to the physician providing care for this group and shared information about the union organizer's interest. The physician agreed that it would be a helpful resource for the workers. I contacted the patient we had seen initially and, through an interpreter, explained the organizer's interest and gave the patient his name and number. I knew that by doing so the possibility for outside intervention was now being opened and that the clinic's decision to act alone on behalf of the workers might come under some scrutiny, but felt that this was a necessary step.

Within 72 hours of that phone call, the workers had been organized and plans were underway to bring them out on a strike for wage, health, and safety improvements. To launch the union's campaign, the organizer had contacted the local health department, the regional office of OSHA, the press, the mayor's office, the local office of



environmental protection, the state attorney general, and an organization representing the community in which the plant was located that had long wanted the plant shut down. When I received a call from the organizer letting me know that these groups were converging at a meeting later in the day at his union headquarters, I immediately let the director of the clinic know so that a spokesperson from the clinic could be present to explain the clinic's decision to work privately with the employer rather than risk the consequences of inaction on the part of OSHA. While initially this turn of events created some friction within the program, as the strike progressed the workers' plight became a cause célèbre throughout the state and the clinic was hailed for its work on behalf of the workers in uncovering the problem and bringing to light the weakened state of federal occupational safety and health oversight at the federal and regional levels. Within four months, the union was voted in and the occupational health clinic was contracted by the company to provide on-going occupational healthcare, medical surveillance, and consultation as part of the stipulation of the contract.



### Post-script: Using an Indirect Path to Effect Direct Action

In an interesting study about the issue of power on the team, one author writes about the nurse (DiPalma, 2004, p. 305):

*"There was no direct path for her to address her concern within the current system other than trying to influence an open-minded physician to write an order for a consultation, and there was no other obvious forum in which she could engage with others in a productive discussion about her concerns and frustrations. The only paths she could use were indirect."*

In some way this statement resonates with me in the context of this reflection. In "connecting with community resources"; in speaking with the director of a long-standing health care agency, knowledgeable about issues of health and safety for Latino workers; in following up a lead that this director provided to a union organizer *specifically* interested in organizing Latino workers around the issue of workplace hazards; in utilizing an existing formal committee structure as a vehicle for inviting labor's voice; in speaking with the attending physician (in lieu of raising the issue in a staff meeting) who I was reasonably assured would agree to providing this contact as a resource to her patients; in contacting the worker personally to let him know about this resource and the fact that the union organizer was interested in speaking with him about working conditions at the plant; in short, by paving a path for possible direct involvement of the workers in addressing the problem they faced, should this be something they desired, and linking this with the physician's recommendations, I had more than an inkling of what would be the likely outcome of these efforts. But due to the fact that a different course of action had been chosen by the team that limited the workers' opportunity to take action on their own behalf, to some extent I had taken an indirect path to arrive there.



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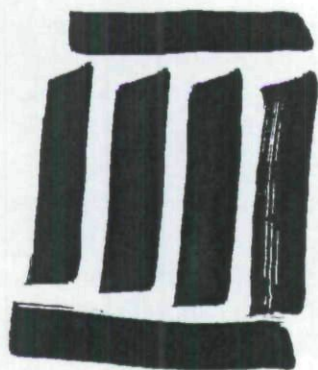
## Footnotes

<sup>1</sup>Provisions under Section 11(c) of OSHA include protection for employees who have exercised rights to refuse to work when faced with an imminent danger of death or serious injury. Retrieved from <http://www.osha.gov/Publications/3021.html>.

<sup>2</sup>Expounding on the provisions of the Dellums Bill, journalist Joan Barbuto wrote: The bill would create a U.S. Health Service to provide all citizens, without charge, medical, dental, and mental healthcare delivered by salaried health workers. It would emphasize occupational health services and the presentation and treatment of illness. The system would be governed by elected community boards supervised by district and regional boards and a National Health Board. Healthcare would be provided through facilities maintained by the service including community health centers, doctors' offices, nursing homes, district hospitals, and regional medical centers. The service would be financed by a surtax on individuals and corporations, the elimination of health deductions on income tax, and Medicare and Medicaid funds.

<sup>3</sup>For an analysis based on the perspective of one of the medical team members, see Cowan's thesis: "Ms. Lewis also recognized that there were more issues to resolve than just those involving health and safety. Workers had no benefits, were required to work 12-hour shifts, and were fired indiscriminately. They needed more help than the clinic or an attorney could provide" (Cowan, 1988, p. 52).

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