LEAD POISONING (A)

This case traces the efforts of a large number of individuals in and out of government to solve the lead poisoning problem in New York City. Everyone in modern urban society absorbs some lead into his system as he breathes, eats, or drinks. As much as 50 micrograms of lead are commonly absorbed and excreted daily by a normal adult, and a residual lead level of 20 micrograms per 100 milliliters of blood is common. However, excessive amounts of lead in the body can cause lead poisoning. While the level of lead in the bloodstream is not itself a dependable predictor of damage, some doctors think that long-term lead levels of only 40 micrograms can cause mental damage; children with 60 micrograms per 100 milliliters of blood are definitely considered to be in danger.

Lead poisoning can cause mild or severe retardation, kidney disorders, epilepsy, and occasionally death. It primarily affects slum children who eat chips of lead-based paint that peel from tenement walls. According to studies done in the 1960s, 10 to 25 percent of children from one to six years old living in the slums of Eastern and Midwestern cities had absorbed dangerous quantities of lead. Up to five percent had actual clinical symptoms of the disease.

Not all kids chew on paint chips in their environment. But up to 50 percent of all children between the ages of one and six have some form of pica, a craving to eat or chew on non-food substances. For the small child with pica, dilapidated housing with peeling paint or plaster is almost certain to be hazardous. Lead-based paint for interior walls has not been widely manufactured since about 1940, and its use for interior walls has been illegal in New York since 1959, but it was still on the walls of most slum housing in the 1960s (except in Western states, where slum housing is generally post-World War II). Even if it is several layers below the surface, a dangerous amount of lead may be present in a few
paint chips the size of an adult thumbnail, and poisoning is almost certain is such chips are ingested regularly over a period of several months.

For the first weeks of a child’s continuous ingestion of lead, no visible symptoms may appear. When they do, they are often very unspecific--irritability, fatigue, nausea. At this stage, the disease is often diagnosed incorrectly, and a chance to prevent permanent damage is lost. If, at that point, the child eats no more lead, he will probably recover, though the lead remains in the system for as much as a year and may impair his intellectual capacity. No one knows just how many of these undetected cases exist. A child who continues accumulating lead will have convulsions or paralysis, and eventually go into a coma. Lead encephalopathy, as this stage is called, swells the blood vessels of the brain and does permanent damage to the central nervous systems of 25 to 40 percent of its victims even if they are treated. In many cases this means extreme, permanent retardation.

As the result of better treatment methods developed in the 1960s, the lead poisoning mortality rate has dropped to the point where in 1969 there were only two recorded deaths from lead poisoning. A poisoned child is treated with chelating agents, which draw out the lead. This treatment reduces the lead level promptly but does not eliminate it completely. The chances of complete recovery after treatment are significantly lowered if a child is re-poisoned.

How serious was the problem in New York City? An estimate based on the Housing and Vacancy Survey of 1968 suggested that 1,350,000 people were living in deteriorated or dilapidated housing old enough to have lead-based paint still on the walls. With nine percent of the city’s population between the ages of one and six, the number of children at risk was estimated at about 121,000. Estimates by the Health Department officials of the number of children who Approximately 16.9 percent of these children will be born into an environment actually had dangerous amounts of lead in their blood varied from 6,000 to 30,000. Most of these cases went undetected: only 727 cases were reported in 1969.

A study on lead poisoning prepared in 1969 by an independent consultant interpreted the impact of lead poisoning on the 25,000 children born in New York City in a single year as follows:

1. Approximately 16.9 percent of these children will be born to an environment containing large quantities of lead and will become part of the population at risk approximately one year after birth;
2. Approximately 3,750 of the 25,000 children will ingest extensive quantities of lead during their first six years of life;
3. As many as five percent of these children could subsequently die from lead poisoning;
4. As many as 1,000 could suffer irreparable brain damage;
5. An unknown number could develop disorders such as kidney malfunction and cardiovascular and renal damage.

The costs of lead poisoning to its victims are obvious. The costs to society are also staggering. Dr. Julian Chisholm, an expert on lead poisoning from Johns Hopkins Medical School, estimated in 1969 that a severely brain-damaged child who required institutionalization would cost society more than $220,000 over his or her lifetime, and special education for a mildly retarded child would cost $17,000. Treating a child whose case is diagnosed early costs $1,000 or $2,000; to patch or repair the peeling walls of a child’s home costs about the same. None of this takes into account the loss to the country of the potential productivity of the damaged children or the tragedy of undiagnosed, brain-damaged children meeting frustration in ghetto classrooms.

Background of Government Inaction

As serious as the lead problem was, New York City’s large and sophisticated public health bureaucracy had done very little to counteract it. In the mid-fifties a study was done in Jamaica, Queens, which showed that large numbers of children living in dilapidated housing were suffering from lead poisoning. As a result of this study, procedures were developed for hospitals to report cases of lead poisoning to the Health Department when they discovered them. Reports also came from the Health Department’s Child Health Stations, although children were routinely screened at the Health Stations only at the age of three months, when they were much too small to get at painted walls.

Whenever a case of poisoning was reported to the Health Department, one of the department’s sanitarians was supposed to check the child’s apartment for lead paint. If such paint was found, the child was referred to a doctor and the landlord was ordered to patch the area. However, unresponsive landlords were fined only five to seven dollars. The Housing and Development Administration took over the Health Department’s responsibility for repairs in 1965, but there is no evidence that the homes of poisoned children were repaired with any regularity: for example, the lead poisoning recurrence rate was about 50 percent at one large New York City Hospital. The 1969 study made clear the haphazard nature of the referral process and the Health Department’s essentially passive role. (See Appendix A for excerpts from the study.)

The broader history of the Health Department shows a good deal more concern for New York City’s poor than is evident from its record on lead poisoning. For example, Child Health Stations established in the 1920s dispensed free milk and universal inoculations to thousands of immigrant children. Yet lead poisoning, with an incidence higher than that of many diseases given priority by the Health Department, was largely ignored by both the health and housing bureaucracies and by City Hall.
Some attributed the city’s inaction to institutional racism and the fact that lead victims were poor, non-white, and politically unorganized. However, Health Department officials maintained that little was done because there was never any money to combat lead poisoning—although they had asked the Budget Bureau for many years to approve funds. While it is certainly true that health budgets were very tight during the late 1960s, with all new monies expended on Medicare and Medicaid, officials also acknowledged that then-commissioner O’Rourke never acted on requests within the Health Department for more resources to fight lead poisoning, and in fact no written budget submission in the late 1960s shows any formal request for lead poisoning funds.

The Health Department was handicapped not only by its budget but by its personnel. People of real ability had come into public health during the Depression because it promised secure positions. By the 1960s most had left the field altogether or moved up and beyond the New York Health Department. In 1968, there seemed little chance of getting superior doctors into middle-level positions where they could run a lead poisoning program. A bureau director in that year received only $14,000 a year—a salary hardly competitive with the rewards of urban private practice. And with no budget, lead poisoning was not a program on which to build a public health career. Similarly, there was a shortage of sanitarians to check apartments for lead-containing surfaces; the position required a college degree but paid a very low salary.

Within the Health Department, the bureaucratic process for dealing with lead poisoning was fragmented. Community education was the responsibility of the Bureau of Public Health Education; the nurses who visited apartments and checked the paint were provided through the Bureau of Public Health or through the District Health Service office; the Child Health Stations which reported lead poisoning cases were under the Bureau of Child Health; the inspections were the responsibility of the Environmental Health Services Department; and there were some residual responsibilities in the chronic disease section of the Health Department.

There were also technological problems. The best test for lead is a blood lead measurement, which is expensive to administer, time-consuming to interpret, and traumatic for the child. And since lead that is stored within bones will not show up in blood tests, the tests may be unreliable. The Health Department’s solution was to require a blood lead test, an X-ray, and a urine measurement before a child’s condition was established. This diagnostic rigor made mass screening impossible, given the department’s budget limitations.

Finally, health officials felt that even if they received funds to test and treat children, the key to the problem lay in prevention—and prevention required ensuring that small children did not live in or visit apartments with leaded surfaces. In a city with a vacancy rate approaching zero, immediate relocation of families exposed to lead paint was impossible.
And to de-lead every apartment where a susceptible child lived would cost more than even the best of landlords would be willing to pay and more than the city had—perhaps $150 million. Apart from complete reconstruction, the techniques available for dealing with lead-base paint on walls were very limited: burning it was illegal due to the dangers of noxious fumes; sanding it off only sprayed lead dust around the apartment, and covering it with plaster board did not constitute “removing” it within the meaning of the existing law.

Early in Mayor John Lindsay’s first term, lead poisoning was apparently discussed as a possible area of expansion for the Health Department, under Health Services Administrator Howard Brown. This possibility, however, was rejected because lead was felt to be primarily a housing problem. In general, Health Department officials in 1968 thought that the amount of cooperation between the health and housing bureaucracies necessary to solve the lead poisoning problem was unlikely to develop. From their point of view, finding and treating lead-poisoned children was not a cost-effective way to spend health money in the absence of a housing repair program. And the housing people thought that nothing short of total rehabilitation or relocation would really deal with the problem. The impasse and the resulting frustration were summed up at one point by a city official commenting on the three problems of lead poisoning, alcoholism, and hypertension:

Wasn’t it stupid, really? That in New York City, where you have this incredible medical establishment of 19 municipal hospitals, maybe 70 voluntary hospitals, seven medical schools, and 2,000 shrinks—wasn’t it incredible that you couldn’t get that establishment focused on those problems?

Pressure From the Outside

While City Hall was stalemated, various community groups were becoming increasingly concerned about the lead problem. Prominent among these groups was the New York Scientists’ Committee for Public Information (SCPI), and organization formed in the late 1950s to “give to citizens the scientific information needed for making sound judgments on public policy issues involving science.” Its members are medical doctors, physiologists, and professors from all the major medical schools, universities, and research centers in and around New York City. Secure in their professional status, the members of SCPI claim an obligation to use their scientific skills for broader social ends than are normally served by their individual disciplines. Participation in SCPI is often their only form of political activism; few members of SCPI have any experience with government bureaucracies or politicians.

SCPI began gathering and disseminating information about lead poisoning in 1967. Late that year, several members of SCPI, including co-chairman Glenn Paulson, went to a St. Louis meeting with other members of organizations from the “science information
movement.” Sponsored by the national coordinating body of these local committees, the Scientists’ Institute for Public Information, the meeting included a presentation of reports on lead poisoning in Rochester and Chicago. Both of these cities were testing larger proportions of the risk population than was New York. The New York delegates suspected that New York’s lead problem was at least as serious.

Returning from the St. Louis meeting, these SCPI members joined together to form a special subcommittee of SCPI to study the problem and disseminate information to community groups in the city. They held their first meeting in February 1968, and shortly thereafter began collecting information about the lead problem and what was being done about it. Among the most dedicated of the group was co-chairman Paulson, a graduate fellow in environmental science at Rockefeller University and, at 25, a member of the Mayor’s Council on the Environment. Paulson estimates that he spent 50 percent of his time during that spring working on lead poisoning. He and the other subcommittee members contacted every neighborhood organization, settlement house, community health center, and community action group that they or their friends had heard of.

The lead subcommittee decided in late spring to run a small testing program in order to dramatize the problem and establish its prevalence. To obtain help in conducting such an experiment, the subcommittee organized a meeting at Rockefeller University which more than 35 community groups attended. While some organizations did express interest in the problem, no organization volunteered to sponsor the test and collect the urine samples in a slum area. Eventually, however, a medical student from the Albert Einstein School of Medicine, who thought the project would interest fellow students, persuaded Einstein to allow students some lab space while SCPI gathered donations of money and equipment.

During the program, SCPI sent a member to help in the lab every day until it was clear the medical students could do it alone. Neighborhood children collected urine samples, and medical students analyzed them. Of the 409 samples from children under six living in dilapidated housing in the South Bronx, 89, or 22 percent, showed possible poisoning. The data, however, were never officially released. (SCPI members contend that the data were so striking that a high official at Einstein withheld them in hopes of using them to get a federal grant to study the problem.)

That same summer SCPI began to disseminate information on lead poisoning through broadcasts over WBAI-FM, a listener-sponsored station with a limited audience. With two representatives of the black community they took part in a discussion of the problem. This and other broadcasts on lead poisoning were given during the summer on Glenn Paulson’s own WBAI show, “Scientists Speak Out.”

During the spring of 1968, Paulson heard about and contacted Paul DuBrul, a housing specialist in his early thirties with a long history of involvement in liberal and radical
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causes. DuBrul had been, at one time or another, a labor journalist, union organizer, housing director of a large community service organization, and urban planning teacher at Pratt Institute. DuBrul had never heard of lead poisoning, and he was appalled at what Paulson told him. Very quickly he began putting SCPI members in touch with his contacts in politics, the media, and community groups.

Although DuBrul and SCPI members were unable to gain access to the Health Commissioner or the Housing and Development Administrator, they did meet with Dr. Donald P. Conwell, assistant commissioner of Health for Preventable and Chronic Diseases. Cronwell acknowledged the seriousness of the problem and estimated that, in spite of the fact that the Health Department was reporting only 200 lead poisoning cases a year, there might be as many as 20,000 or 30,000 actual cases in the city. However, he cited a tight budget and a lack of public awareness as obstacles to an adequate program; outside pressure, he suggested, would put him in a better position to take action.

DuBrul and the SCPI group then turned their attention to politicians. Since the incentives to respond seemed greater for City Hall than for the Health Department, particularly a year before the mayorality election, they concentrated their energies on the mayor’s assistants for health and housing, providing them with information about the issue and making proposals for action. They met with little success. Although the mayor’s housing assistant later recommended a lead program to the Model Cities administrator, he generally despaired of a housing solution. The health assistants, aware of the problem and apparently sympathetic, talked about funding a pilot program, but never managed to produce one.

In late summer of 1968, DuBrul, Paulson, and the others reached the conclusion that they needed a specific, conscious strategy for pressuring an otherwise reluctant city government. Innocent children were being irreversibly harmed and the lead activists resolved to publicize the problem and the tragedy of governmental indifference. As DuBrul put it, they would create for the city a “counterbalancing cost of not making É an investment” in a lead poisoning program. Moreover, the group decided that medical identification of lead poisoning victims--not lead-contaminated housing--should be the immediate goal. The city’s housing problems went way beyond the lead issue, and a focus on health could be much more specific.

SCPI, with most of its membership drawn from the academic scientific community, was not intended to work with community organizations as an activist pressure group. It soon became clear that an activist organization, with a broader mandate than SCPI, was needed to act on lead poisoning, and DuBrul was the obvious person to lead such a group. DuBrul dates his real commitment from August 19, 1968: on that evening he attended an open meeting sponsored by the central Brooklyn Coordinating Council where he, Joel Buxbaum of SCPI, the parent of a poisoned child, and a medical student spoke. During
that meeting the audience was shown lead-based paint chips collected from the pediatrics ward in the very hospital where poisoned children were treated.

After the Brooklyn meeting, slum residents and people from SCPI and health-related organizations in the city formed Citizens to End Lead Poisoning (CELP). The group’s program called for three kinds of activities:

1. Case detection, to be conducted by community residents through antipoverty programs, neighborhood health councils, etc.
2. Strict code enforcement, prompted by community pressures against health and housing agencies;
3. Community organization, to bring the crisis to the attention of ghetto residents whose children were in danger.

The sentiments of CELP members were reflected in the “Action Program” written by DuBrul:

No progress will be gained in the battle against lead poisoning without massive mobilization of the ghetto community. We have already been told by the Health Department that no money can be found for a testing program until the black community begins yelling “murder.” Previous experience has shown that existing agencies only respond in the face of crisis; the crisis exists; we have to draw attention to it. É

Lead poisoning must become a political issue on a state and local basis. 1969 is an election year. Delegations should make the issue strongly to local candidates. The Mayor himself should be the central focus of all actions; he needs minority votes to be re-elected. “Get the Lead Out” campaign should be begun, with buttons, stickers. In addition, detailed articles should be prepared for politically important journals such as the Village Voice. Careful notes should be kept on all meetings with public officials.

The group was aware, apparently, that obtaining official support would not be easy.

More Slow Than Steady

From mid-1968 to mid-1969 the Health Department showed signs that it intended to act, but concerned observers saw few results. In the late spring of 1968 Commissioner O’Rourke established a task force, including several bureau directors from within the
department, to study the lead poisoning problem and the department’s lead-related programs. Dr. Oliver-Smith, a senior public health physician, reported to Assistant Commissioner Conwell as staff for the task force and as full-time lead poisoning coordinator for the department. It is not really clear, however, whether O’Rourke’s action in establishing the task force was a political response to outside pressure or simply a professional response to the increasing number of poisoning cases being reported.

A few months after the task force was established, the press began to take note of lead poisoning and the growing campaign to combat it. On August 26, 1968, the New York Daily News ran a story about lead poisoning in Brooklyn. Focusing on the case of a two-year-old boy in a coma at King County Hospital, the article went on to report the meeting in Brooklyn that led to the formation of Citizens to End Lead Poisoning. In the same month, an article reporting on Boston’s lead poisoning problem appeared in a professional journal read by most doctors (Medical World News). Still, the coverage by newspapers and journals was generally spotty, with little in-depth analysis of the problem. Consequently, it generated little public concern.

The city’s efforts in the lead poisoning area during the year following the creation of the task force were not impressive either. Dr. Oliver-Smith, generally acknowledged to be a well-intentioned, honest person, showed little sophistication in dealing with the problem. Her new job had no precedent in the Health Department; she had no staff and her duties were only loosely defined. Her responsibilities included (1) checking that a public health nurse and a sanitarian had been sent to the apartment of each poisoned child; 2) making recommendations to the Housing and Development Administration concerning the repair of apartments with lead paint on the walls; 3) developing a register of lead poisoning cases to serve as the basis for future research; and 4) certifying cases of lead poisoning for the Housing Authority, which was to give these families priority consideration for public housing. This minimal list of responsibilities did not readily lend itself to the formulation of an aggressive, far-reaching poisoning control program.

The “lead activists” were very critical of Dr. Oliver-Smith, claiming that she was unresponsive to inquiries and that her research objectives were misguided. For example, while expert medical opinion agreed that paint was the principal source of lead poisoning in ghetto children, Dr. Oliver-Smith’s research focused on lead in clay products.

Dr. Oliver-Smith was most strongly criticized for her handling of case referrals to the Housing Authority. In August of 1968, a procedure was established whereby the Health Department—through Dr. Oliver-Smith—would certify to the New York City Housing Authority emergency cases to be given priority for public housing. From that time until the fall of 1969, the Tenant Selection Division of the Housing Authority asked Dr. Oliver-Smith for opinions on more than 200 applications involving lead poisoning—without obtaining a single response. Late in August of 1969, under great pressure, Dr. Oliver-
Smith informed the Housing Authority that the Health Department would soon get moving on the lead poisoning cases. By the end of October, the Health Department had provided reports to the Housing Authority on slightly less than half of the cases submitted to them.

Dr. Oliver-Smith’s immediate superior, Assistant Commissioner Conwell, was equally slow to act. When first approached by lead poisoning activists, he had been sympathetic but pessimistic, citing such difficulties as paint removal and cooperation with housing agencies. He also pointed to departmental concerns of higher priority, such as venereal disease. At a later meeting with representatives of SCPI and CELP, Conwell promised to put new emphasis on public education about lead poisoning. Yet it took nine months to get a poster approved by the commissioner and fifteen months to get approval for sending out lead poisoning information sheets with welfare checks. As finally distributed, the information sheet was full of complicated information in technical medical language.

Health Department efforts were plagued by other false starts. At one point, for example, it was decided that a pilot study of a screening device to test children for poisoning should be undertaken at Brooklyn Jewish Hospital. A year later the study had not been done. The Health Department sent Dr. Oliver-Smith to look at a more comprehensive lead program in Baltimore, with no apparent result. When a department official sent a “lead poisoning editorial” to all the weekly newspapers in the New York area, no one followed up on the mailing, and the editorial appeared in very few papers. Meanwhile, a sanitarian was assigned to develop better procedures for testing apartments for lead, but he was given no authority over his fellow sanitarians, and too few sanitarians positions were filled to test any significant number of apartments.

The bureaucratic tangles of the period are epitomized by the city’s efforts to obtain laboratory facilities for analyzing blood tests. The processing of some of these tests creates noxious odors which require metal fume hoods to prevent their circulation in the air of the laboratory. When the new central Health Department lab was built in the mid-sixties, the city’s twelve fume hoods were moved from the old facility to the new one, whereupon it was discovered that the hoods could not be installed in the new lab as it was then designed. Minor modifications were made in the building so that at least two of the hoods would work, but the city’s capacity to test for lead was severely reduced just as doctors in the city’s hospitals and child health stations were becoming aware of the needs for the tests.

Similar delays were encountered in the handling of urine ALA tests. These tests indicate the amount of delta-aminolevulinic acid (ALA) in urine, which accumulates at levels 10 to 15 times above normal when the body’s burden of lead is dangerously high. A new technique was developed in 1967 for extracting and analyzing the ALA, quickly and at relatively low cost; a single technician, for example, could process 200 tests in four or five hours. From 1966 to 1968, 68,744 children were tested in Chicago, where one doctor
found a 91 percent correlation between high urinary ALA and clinical diagnosis of dangerous lead absorption. Another study, however, found the urinary ALA test unreliable. The Bio-Rad Laboratory, which was marketing the test, offered 40,000 free tests to the city in an effort to prove its reliability.

City officials, however, were put in an uncomfortable position by this offer. If the offer were made public, and the Health Department refused it, they might appear callous. Yet they had substantial doubts about the reliability of the test, and gearing up to administer the test would require expenditures of time and money. They may have worried also that the tests would show the prevalence of lead poisoning to far exceed the department’s capacity to cope with it.

At first the Health Department announced that the tests were unreliable, and therefore would not be accepted. Then, when SCPI and CELP and a City Council candidate all began to put pressure on the city, the Health Department reversed itself, saying that it would accept only 2,000 kits at a time, since it could not administer all 40,000 tests right away. There was further delay as the mayor’s office debated whether the mayor or the commissioner should accept the tests publicly. Finally the test were accepted by the commissioner, but no procedures were set up for their use. Health Department officials actually appeared reluctant to distribute them to hospitals, and at one point Metropolitan Hospital was prepared to go out and purchase the tests, even though they had been given free to the Health Department.

While the city bureaucracy stumbled along, active concern about lead poisoning increased in early 1969 among scientific and medical professionals and among local politicians. A second lead poisoning conference in March 1969 contributed significantly to the pressure building on the city. Held at Rockefeller University, it was sponsored by the Health Research Council, the City Health Department, the Public Health Association, SCPI, and the Scientists’ Institute for Public Information. Although its findings provided most of the participants with little new information, the conference did constitute open recognition that the essence of the problem lay in deteriorated housing and that the ultimate solution lay in the correction of poor housing conditions. Further, the conference was an important legitimizing device for the groups which had been lobbying for attention to the problem. At the close of the conference a “continuing committee on lead poisoning” was formed with several subcommittees, each of which contained a mixture of people from the public health establishment and activists from medical and scientific professions. Although the Health Department had not sent its top staff, the continuing committee included people like Dr. Bernard Davidow, head of the department’s laboratories and an important ally in the effort to expand the testing program.

Dr. Rene Dubos, the much-revered and influential Professor of Environmental Biomedicine at Rockefeller University, served as chairman of the two-day conference. His
closing remarks expressed perfectly the sentiment which had guided the various pressure
groups in their work on lead poisoning over the past months: “If we, with all our
technological means, are not willing to make the limited effort that would be demanded to
get rid of this disease, then our society deserves all the disasters that will come to it.”

In spite of the activities of the various groups concerned with the problem, it was not until
after a publicized tragedy that New York politicians became aroused. On April 22, 1969,
Janet Scurry, aged 3, died at Morrisiana Hospital of acute lead poisoning. She had been
admitted to the hospital on April 15 in convulsions and a blood lead test was taken on the
17th, but it was not processed by the Health Department until the day she died. After her
child’s death, Mrs. Scurry began to work with CELP to alert other mothers in her
neighborhood to the dangers of lead poisoning; she also spoke about the tragedy in a
broadcast on WBAI. Shortly thereafter, Paul DuBrul brought the incident to the attention
of Robert Abrams, a Democratic Assemblyman running for Bronx Borough president.

On Monday, June 2, Abrams, with Mrs. Scurry at his side, charged that the City Health
and Hospital Department had been “scandalously slow” in responding to the disease. He
called for routine testing of all children at health facilities in high-risk areas, new testing
equipment for all hospitals in those areas, and the utilization of Neighborhood Youth
Corps and anti-poverty programs to provide community education and to conduct a mass
testing program of all children living in deteriorated houses.

At about the same time, Carter Burden, a reform Democrat running for the City Council
from the Upper East Side and East Harlem, entered the picture. Coming from a wealthy
family, Burden had sufficient resources to pursue a broad range of issues, so DuBrul
concluded that he was a likely supporter on the lead poisoning issue. Burden had never
heard of the disease, but DuBrul’s story appalled him. Burden assigned a staff member to
gather information, and, when he became thoroughly convinced that the problem was
serious, he wrote a letter to the mayor asking what was being done. He got no answer.
Burden then asked the same question of the Health Department. After meeting much
resistance, his staff member was finally able to speak with Dr. Oliver-Smith, who
summarized the reasons why the Health Department could do no more than it was
presently doing.

Congressman Koch, another reform Democrat from Manhattan, wrote to Mayor Lindsay
in early June to urge that he set up a lead poisoning program. Citing work done in other
cities, he stressed the importance of screening programs and the need for giving families
with a poisoned child top priority for public housing. He got what he considered
unsatisfactory responses from the Lindsay administration.

The mounting pressure served to bring out the essential inability of the city’s health
bureaucracy as then constituted to do anything decisive about the lead poisoning problem.
In the Health Department, Dr. Conwell was in charge of meeting with community groups concerned with lead poisoning. At one point a group of mothers of poisoned children visited him to complain about Health Department inactivity, and for a time in 1969 he met with SCPI every six weeks to discuss progress. But Conwell apparently could not muster sufficient indignation about the problem to rouse the department into effective action, and he was himself preoccupied with other problems that seemed more easily solved. Also, although he was nominally in charge of the entire lead poisoning program, he had no authority to go directly to the Budget Bureau to request funds, or to pull together all program functions under one administrative mantel.

The potential for Health Department action in late 1968 and 1969 was further limited by bureaucratic turmoil within the department that sapped the time and attention of department officials. Conwell and another assistant commissioner had come to the department from the Public Health Service and met with considerable resentment from the department’s career officials. There was evidence of jockeying for the various assistant commissionerships and also purely personal animosities that divided the Health Department just below the top levels. Largely as a result of these hostilities, Conwell’s administrative area was eventually split into two units, with the federally supported programs (for example, tuberculosis and venereal disease services) going to one of the career city officials.

In addition to the department’s internal troubles, there was considerable uncertainty at this time about the leadership of both the Health Department and the Health Services Administration. Health Commissioner O’Rourke had been in trouble with the mayor on several occasions in 1968. Finally, during February 1969, when there was a severe flu epidemic, a fuel strike, and heavy snow, the Board of Health declared the city to be in a state of imminent peril—just as the mayor was reported to be leaving for a vacation in the Bahamas. O’Rourke was immediately fired, and until July 1969, the department was headed by an acting commissioner. In addition, most observers felt that the health Services Administrator, Bernard Bucove, was not working out as well as had been hoped.

Although the Bureau of the Budget (BOB) might have acted to fill the leadership gap, it too did nothing. Since Lindsay’s election, BOB had become very active in guiding policy in many of the city’s departments, and in fact, the Program Planning Unit of the Budget Bureau often operated as the principal planning staff of the mayor’s office. But BOB was helping the Health Department plan a major program of comprehensive child health services, and the use of scarce funds to attack what they saw as an isolated problem did not seem efficient or appropriate. Furthermore, an expanded lead poisoning effort would involve more sanitarians, and the Performance Standards unit of BOB had found that many sanitarian slots went unfilled because they paid extremely low salaries, but still required college degrees. There is no evidence that the Budget Bureau tried to fit lead
poisoning into any of its larger program plans during this period, not did it attempt to study the issue in more depth.

The Issue Goes Public

In the face of official inaction, only the mobilization of popular support seemed to offer any hope for change, and the work which lead activists had been doing to educate and organize community groups seemed to be paying off. On July 1, 1969, the Health Department got a new commissioner, Dr. Mary McLoughlin, who had come through the ranks as a district health officer and had long been concerned with lead poisoning. Soon after her appointment, she requested a budget modification that would enable her department to give lead poisoning some priority. After a lot of pulling and tugging between the Budget Bureau and the Health Department, a budget modification was approved which allowed the commissioner to shift $150,000 to lead poisoning from a $500,000 fund for low-priority programs.

On October 5th, Commissioner McLaughlin announced “a stepped up attack on lead

1. The $150,000 fund transfer;
2. An attempt to revise the city’s health code to require landlords to cover lead-painted surfaces with wallboard;
3. The development of a small staff to work solely on lead poisoning;
4. An extensive study of the ALA test; and
5. The purchase of laboratory equipment for measuring lead in walls and testing children for poison.

This increased activity was intended to enable the Health Department laboratories to perform 500 blood lead tests per week (a 400 percent increase), 250 ALA tests per week, and 100 paint analyses per week. It was estimated that these increases would enable the Health Department to identify an additional 2,500 cases of lead poisoning for the year.

The money and attention were welcome news to those who had worked so long to get action. They also raised expectations at a time when lead activists were by no means satisfied with the city’s effort. City council candidate Carter Burden had already referred to lead poisoning in his speeches, but in September he came down hard on the issue. A doctor from Metropolitan Hospital had called Burden’s office in the summer about a severely poisoned child he had been treating. Two members of Burden’s staff went to the hospital and saw the sick child, Gregory Franklin, who could no longer see, hear, or recognize people. His family lived in an East Harlem building, which, at the time of Gregory’s admission to the hospital, had 96 outstanding housing code violations. Tests conducted by Burden’s staff, helped by SCPI members, showed that every room in the apartment was a lead menace. Burden held a press conference to draw attention to
Gregory’s plight; it was covered well by television, but received no attention in the daily papers.

Burden’s staff also attempted to get the Franklin family into a public housing project, where there would be no lead threat. They wrote letters demanding more systematic and comprehensive lead poisoning activity to Maurice Reichman, commissioner of Rent and Housing Maintenance; Dr. Oliver-Smith of the Health Department; Dorothy Spencer, district supervisor of the central Harlem District Health office; and Ira Robbins, vice chairman of the New York City Housing Authority. Only Mr. Robbins indicated any willingness to take action on the problem: after an exchange of three or four letters with Mr. Robbins, in which he detailed many bureaucratic obstacles to a solution, the Franklins were finally admitted to a public housing project.

On September 18, Jack Newfield, a widely-read political writer and an old college friend of DuBrul, wrote what was to prove a very influential front page article in the Village Voice on lead poisoning. His piece presented the case of Janet Scurry, the small South Bronx girl who had died in April; from that case he elaborated on the dangers of the disease, the indifference of the city hospitals to its victims, and the inertia of city government. He called the efforts of CELP and SCPI “a lonely crusade, bereft of money, manpower, and organizational support, to pressure the city and the health establishment, and to alert parents.” He credited Carter Burden with being “the only politician in the city who seems genuinely involved in the issue.” Perhaps most importantly, he lambasted the news media for not seizing upon the lead as a major public health issue. Expressing his frustration with journalists who didn’t find lead poisoning “newsworthy,” he noted that:

...lead was a story hard to make visible or dramatic for the television networks. It didn’t involve famous leaders, or exotic militants, or public violence. How do you show a process, how do you show indifference, how do you show invisible, institutionalized injustice in two minutes on Huntley-Brinkley? How do you induce the news department of a television network to get outraged about nameless black babies eating tenement paint, when the public health profession, school teachers, housing experts, scientists, the NAACP, and the politicians haven’t given a damn?

The following week in the Village Voice Newfield reported the case of Gregory Franklin. In two succeeding articles he attacked “the anonymous individuals responsible for this tragic situation: city officials, landlords, newspaper editors” for their tendency to “act irresponsibly because they feel protected by their anonymity.” In response to each of his articles, he received many calls and letters form people appalled by what they had read.
For the first time in Newfield’s journalistic career, he became an activist for a local issue. He appeared on a WBAI discussion program and participated in an angry confrontation on television with Commissioner McLaughlin and the mayor’s assistant for health, Werner Kramarsky, both of whom thought the articles had been inflammatory. He contacted other journalists, who wrote pieces on lead poisoning in such publications as The New Republic and Look, helped to push lead poisoning bills in Albany, and encouraged Congressman William Ryan and Senator Edward Kennedy in their involvement with the lead poisoning issue.

Newfield’s articles were read by only a few thousand people--a tiny fraction of potential Lindsay voters--most of whom would not be swayed by a single issue. The mayor’s men did not think they had to reckon with them in the November election, and they were right. But the political effects were nonetheless substantial. Newfield appealed dramatically to the social conscience of upper-middle-class liberals, New Yorkers with influence, including many reform Democrats whose support was increasingly important to Lindsay. The strong response from Newfield’s readers became one more step in a process that had already involved hundreds of community meetings, dozens of confrontations between CELP and the Health Department, and scores of negotiations with the hospitals over treatment of lead-poisoned children.

More community agencies and coalitions were mounting campaigns against lead poisoning in late 1969. The East Harlem Health Council, led by a Health Department District Health Officer (who, some say, was later fired for his agitation on this issue) began to study the lead poisoning problem in East Harlem. Neighborhood agencies on the Upper West Side banded together to force slum landlords to repair lead-painted walls. Local branches of CELP were forcing hospitals to begin testing children routinely for lead poisoning. In July of 1969, Kings County Hospital had begun to give a special test to all children one to six years old who came into its clinic. The Brooklyn Jewish Hospital and Brookdale Hospital, both in central Brooklyn, set up large community education programs as part of their Comprehensive Child Care Program. Brookdale conducted a study of 100 children living in Brownsville slums, and in October the District Health Supervisor reported that 50 of those children had abnormally high lead levels, 15 with levels so high that they required hospitalization.

SCPI, CELP, or Carter Burden’s office had a hand in virtually all of these activities. In the spring of 1968, SCPI members had been in touch with 200 organizations, only a few of which expressed any interest in attacking the problem.

But at the end of the following year, several dozen organizations in the city were in some way involved with the issue, through code enforcement, case detection, community education, or simply pressuring City Hall and the Health Department.
The publicity over the lead poisoning issue had some effect on the mayor, even though the issue did not figure prominently in his re-election campaign. On September 26, in a major speech at the Educational Alliance (written by a speech writer who was an old friend of Jack Newfield), he called for a “new coalition for justice” between discontented middle-class Americans and poor people. He blamed the costs of the Vietnam war for the general dissatisfaction of Americans, charging that the City of New York got a very poor return on the tax monies it sent to Washington:

I want this money kept here, in our homes and schools, in our neighborhoods, in our lives. I want it to complete Gouvernor Hospital here. I want it fighting the menace of lead poisoning in our neighborhoods.

In October, the Board of Health amended the New York City Health Code to permit the Health Department to require walls painted with lead-base paint to be covered with wallboard or other sheathing material. CELP got to work immediately. With the aid of lawyers from the Martin Luther King Health Center, they developed a proposal which made the responsibility of the Health Department mandatory rather than discretionary. The CELP proposal required the Health Department to issue a “cover or remove” order to the landlord whenever the department discovered paint with more than one percent lead on a building’s interior walls, ceilings, doors, baseboards, windowsills, or frames. It also required the Emergency Repair Service of the Housing and Development Administration to be called in to perform the necessary work if the landlord failed to comply with the order within five days; and it specified that the Health Department must post warnings in English and Spanish concerning lead poisoning in an affected building.

At a public hearing on November 20, CELP presented its proposal. To the surprise of CELP members, the department accepted substantial portions of it, including the provision that made the Health Department’s responsibility mandatory. However, the Board of Health did not go along with CELP’s provision for covering the surface to a minimum height of five feet or with the provision mandating public warnings in affected apartment houses. The Health Department was required to “request” rather than “order” the Housing and Development Administration’s Emergency Repair Program to cover walls.

More politicians became involved that autumn. Congressman William Ryan, who had earlier introduced federal legislation to provide support for city programs to combat lead poisoning, helped SCPI to plan and raise money for an informational breakfast for congressman on lead poisoning. Congressmen Jonathan Bingham and Edward Koch co-sponsored the breakfast, which took place on November 12 in Washington, with Glenn Paulson of SCPI moderating and several doctors on the program. Senator Edward Kennedy also spoke, announcing that the following day he would introduce lead poisoning legislation in the Senate.
In November 1969, after the lead poisoning problem had become “hot” news, 200 of the 40,000 ALA tests that had been given to the city were requested of the Health Department by the Young Lords, a militant Puerto Rican organization in East Harlem. Medical students had interested the Young Lords in testing local children and had promised to supervise the laboratory analysis of the Lords would send members around door-to-door to collect urine from children. At first the Health Department stalled, saying that it couldn’t accept diagnoses not based on blood lead levels. Then Dr. Oliver-Smith said she would have to check with the commissioner, and when she did not phone the Young Lords back within a few days, they sat in at the office of Dr. David Harris, deputy commissioner of the Health Department. In response to the sit-in, Dr. Conwell went with the Young Lords to the laboratory to obtain the tests and then delivered them to Metropolitan Hospital, where they were handed over to the medical students and the Young Lords for their testing program. Of the first 40 children tested, 12 showed dangerously high blood lead levels; this result was publicized in the press and added to the pressure on the Health Department.

Mayor Lindsay was elected to a second four-year term in November 1969. The day after the election, a meeting was called to discuss the appointment of a new Health Services administrator (the immediate superior of the commissioner of health). The mayor had been unhappy with Bernard Bucove for some time, and during that meeting the decision was made to appoint Gordon Chase as the new administrator. Chase had begun his government career in the State Department, worked for McGeorge Bundy in the White House, and then served with AID and the Federal Equal Employment Opportunity Commission. Along the way he had earned a reputation as a management whiz. He came to New York in 1968 as chief fiscal officer of the Human Resources Administration with the mandate of cleaning up after some nasty embezzlement scandals, which he did within a relatively short time. By late fall 1969, he was restless and considering another offer outside the city. The mayor appointed Chase partly out of reluctance to lose his talents. It was a rather daring appointment. Chase knew nothing about health and he had never taken on an administrative responsibility of this size or complexity. Neither the new deputy mayor nor the budget director were certain he was the right man for the job. The medical establishment made it clear that it was appalled that the mayor would bring in someone who knew nothing about health. But the mayor defended the appointment on the grounds that the problems of the unwieldy health bureaucracy called for a first-rate manager.

Less-publicized activities were going on in the Health Department at the same time. Dr. Oliver-Smith was fired, and conversations between the Health Department and the Budget Bureau seemed to be leading to a recognition that much more than $150,000 was needed to make a real impact on lead poisoning in the future. The Budget Bureau asked the Health Department to provide it with a study of the need for a new program and the
dimensions of the existing one. The Health Department, in turn, contracted with an independent consultant to prepare such a study for December 1969. Two years after the formation of the lead subcommittee of SCPI, the Budget Bureau’s health planner, the Human Resources administrator, the mayor’s project management staff, and new Health Services administrator Gordon Chase were told by one of Lindsay’s executive assistants that lead poisoning was a high priority for City Hall. The question now was, what would Chase and the others do?
APPENDIX 1

As stated earlier, the Health Department has not had a formal large-scale case-finding program. However, since the department has carried on a limited program, the existing referral sources and the process of confirming a lead poisoning case and the subsequent action that is taken are worth examining.

A primary source of reported cases in the past (but more recently less important) has been the city’s child health stations. A child may be brought to a child health station for any number of reasons. If a history of pica or symptoms suggesting lead poisoning are found, the child is referred to the Social Hygiene Clinic for a blood lead test. It should be noted, however, that children receiving services in child health stations, even those children in the sixteen poverty health districts, are not routinely examined for lead poisoning. A child is referred for a blood lead test only if the attending physician is aware of lead poisoning and its symptoms.

A second source of referral is the Public Health Nurse or Health Guide, who during a home visit may notice peeling paint or plaster. If there is a child in the home and if he has a history of pica and is under six years of age, the Public Health Nurse will refer him to the Social Hygiene Clinic for a blood lead test.

Finally, private-proprietary, voluntary and municipal hospitals are a source of both confirmed cases and referrals. During recent years, the hospitals have been the primary source of reported lead poisoning cases.

As noted, children suspected of having lead poisoning are usually referred by non-hospital sources to the Social Hygiene Clinic; the child health stations do not have sufficient personnel or the necessary equipment to perform a blood lead test. At the clinic, blood samples are taken and delivered to a Health Department laboratory where a blood lead determination is performed. The laboratory report is sent to the child health station or other referral source and to the Poison Control Center’s Lead Poisoning Unit.

If the laboratory analysis indicates a blood lead level of 60 micrograms or greater, the following procedure applies:

I. The mother is contacted and instructed to bring her child to the Child Health Station.
II. The child is referred for treatment if further tests prove positive.
III. Home visits are made by Public Health nurses who:
   A. Look for other children in the family with a history of pica;
   B. Look for other health problems in the family;
C. Obtain the history of the child;
D. May or may not look for paint and/or plaster.
(The nurse’s report is either kept in the district health office or forwarded to the central nursing office)

IV. The Hazardous Substances Division of the Bureau of Sanitary Inspection receives reports of confirmed cases of lead poisoning (cases with blood lead levels of 60 micrograms or greater) and notifies the District Health Office and a sanitarian is assigned to visit the home. The sanitarian inspects the premises for loose paint chips and plaster and takes paint samples from selected areas. These samples are sent to the Health Department laboratories to be analyzed for lead content. If the conditions are found to be hazardous, the landlord is notified of the health violation and a report of the actions and findings is sent to the Central Office. In addition, as of January, 1969, a check list of the noted conditions is forwarded to the Lead Poisoning unit.

Cases referred by hospital sources follow the same process with the exception of some variation in the screening procedure. For example, some hospitals in high risk areas routinely send samples from children under six years of age to the Health Department’s laboratories for a blood lead determination. Other hospitals send blood samples of only those children manifesting one or more of the following symptoms: pica, blood changes, gastrointestinal disorders, and disorders of the central nervous system. The Health Department laboratory after performing the blood lead determination forwards its report to the referring hospital service and the Poison Control Center. From this point, the subsequent activities duplicate those described previously for a non-hospital referral.

Some hospitals, however, conduct blood lead determinations in their own laboratories or in private laboratories. Although the hospitals are requested to report to the Health Department all cases that have been diagnosed as lead poisoning, there is no way, at present, of knowing where hospitals are conducting their own tests and not reporting the results. Since the Health Department has no means for monitoring these cases, the treatment of and follow-up for confirmed cases in this latter category are not known.

Source: This appendix is adapted from a 1969 study done by an independent consulting firm