



VCM Plant

Conoco Chemicals
Continental Oil Company
P.O. Box 605
Westlake, Louisiana 70669
(318) 491-5211

September 12, 1977

Dr. Ludwig Schmidhammer
Wacker-Chemie - GmbH
8263 Burghausen
Postfach 1260
West Germany

Dear Dr. Schmidhammer:

The purpose of my letter is to attempt to determine the situation related to other Stauffer VCM technology licensees related to renewal of the information exchange portion of the Stauffer licensing agreement. At the symposium held in San Francisco in 1976, I believe you indicated that Wacker-Chemie's licensing agreement with Stauffer was due to expire, and that you were of the opinion that the information exchange portion would be renewed.

If you would be so kind, I would appreciate a response from you to the following questions:

- 1) Has Wacker-Chemie renewed the information exchange portion of the Stauffer licensing agreement with Stauffer? If not, when does your agreement expire?
- 2) For what term (how many years) was the agreement renewed?
- 3) Was a renewal charge asked by Stauffer to extend the information exchange agreement?
- 4) How was Wacker-Chemie approached by Stauffer related to the information exchange renewal? By letter, phone call, or personal visit?

I would like to thank you in advance for taking the time to answer these questions. Please stop by and see us on your next visit to the United States.

Sincerely,



J. A. DeBernardi
Plant Manager

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CCR 000056217

Dear

This is the second quarterly letter that is being mailed to each VCM employee reporting on various safety and health activities, plant safety experience and items of general family safety interest. I hope you will share this information with your family members.

Accident Experience

During the second quarter of 1977, the VCM plant experienced six first-aid cases and one medical treatment case. Although this is an increase in total number of injuries as compared to the first quarter of 1977 we are still below our 1976 experience. During the first half of 1976 we experienced twenty-one total injuries as compared to 11 total injuries the first half of 1977. Again, this is still a bit deceiving since we did not experience a plant turnaround in the first half of 1977.

Safety Achievement

On May 17, 1977 the VCM plant completed three years of operations without a lost-time injury. The safety attitude and safe work practices of each employee are the major factors in this accomplishment. This is a notable achievement in which everyone should take great pride.

In recognition of this achievement a safety banquet and dance was held at the Lake Charles Country Club on the night of Friday, June 24, 1977. In addition, a catalog of safety gifts was distributed to each employee from which a gift of their choice was selected.

From what I could observe all those attending the safety banquet had a good time, I know I did. We hope that through each of our efforts we will be able to repeat this event in 1978, after completion of another year without disabling injury.

First-aid training was conducted by Harold Fisher of the Medical Division, Ponca City during the week of June 27th. Training classes were held in the plant for all employees. Also, annight session was held at the Chateau Charles for the families of employees. As usual Harold Fisher did an excellent job

of conducting the first-aid training. If you or your family were unable to attend one of Harold's sessions you missed an excellent presentation. Harold presents first-aid training on a level understandable by all. Mark your calendar now for next year attendance at this training session. You won't regret it.

VCM Physical

Medical testing was conducted in the month of April for all plant employees. The testing was performed by American Health Profiles and included such tests as blood, urinalysis, pulmonary function, chest X-ray, tuberculosis, cancer of the colon, glaucoma and EKG. These tests were followed up with a hands-on physical examination. We feel that not only is it important to perform the basic tests as required by the OSHA VCM Standard, but also to offer our employees additional testing to inform them on other matters effecting their general health status. Letters have been sent from our Medical Division informing our employees of the results of the medical testing.

On April 18, 1977 Bill Henry became the new Safety Director of the VCM plant. Earl Gremillion accepted a transfer and promotion to become the Safety Director of Continental Carbon in Houston. Continental Carbon is a 80% owned subsidiary of Continental Oil Company. Bill was formerly Safety Director of the Oklahoma City PVC Plant of CONOCO Chemicals.

Attached is an article entitled "Drinking - Our No. 2 Killer". I hope you will find this article to be both interesting and enlightening.

Sincerely,



J. A. DeBernardi

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DRINKING: OUR NO. 2 KILLER

By refusing to recognize alcohol as a leading agent of disease, we hamper any preventive efforts

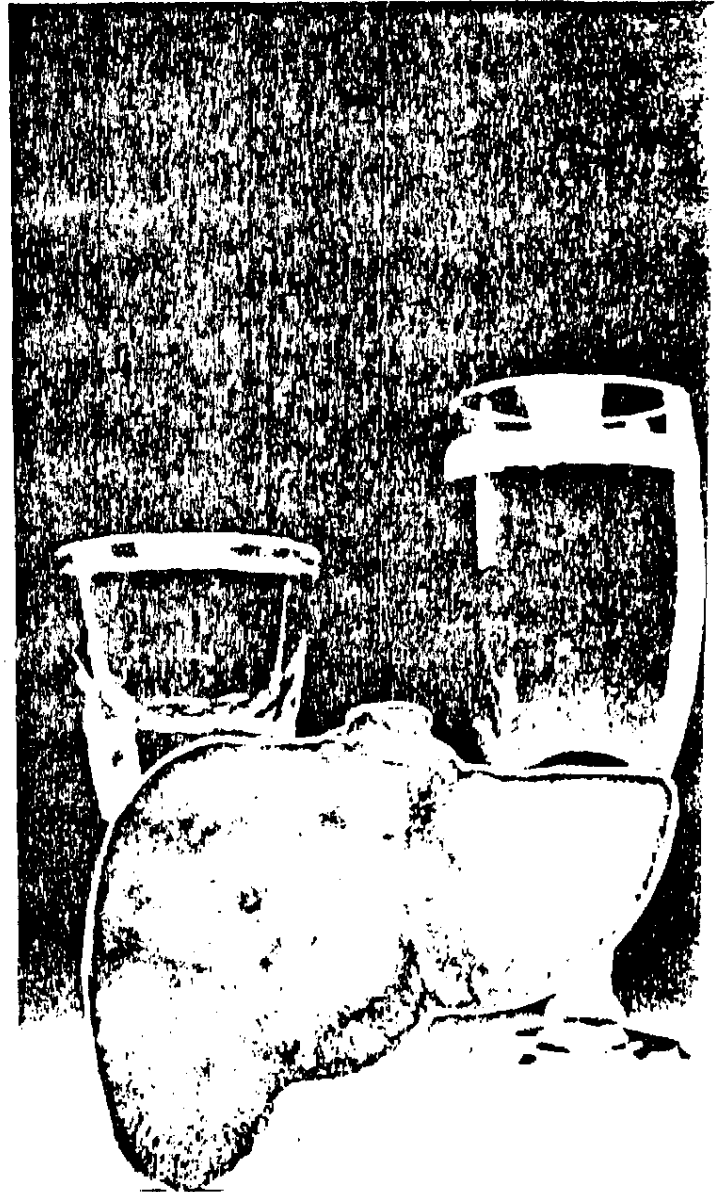
MILTON TERRIS, M.D.

One may say with confidence that alcohol is the second most important known cause of morbidity and mortality in this country, second only to tobacco. Epidemiological, clinical and laboratory evidence has made it clear that cirrhosis of the liver in the United States is caused primarily by alcohol consumption. However, it is only one in the impressive list of diseases associated with alcohol. These include acute and chronic intoxication, toxic psychoses, gastritis, pancreatitis, cardiomyopathy, peripheral neuropathy, as well as automobile, home and occupational accidents, suicide, injuries and deaths due to assault, and cancer of the mouth, pharynx, larynx, esophagus and liver.

The most fruitful approach to prevention lies in the epidemiological concept of the interaction of agent, host and environment. Yet many prominent leaders of the alcoholism-control movement in the United States reject this concept; they refuse to see alcohol labeled as an agent of disease. Instead, they focus all attention on the host. The individual who consumes large amounts of alcohol is considered to be alcoholism-prone on a biological or psychological basis. In practice, this approach avoids preventive measures and almost completely relies on treatment, even though therapeutic results are often unsatisfactory.

In its report to the nation in 1967, the Cooperative Commission on the Study of Alcoholism recommended an educational program designed to "assist young people to adapt themselves realistically to a predominantly 'drinking' society." The purpose is to introduce individuals to alcohol early, within the family, so they may learn to drink in moderation. While this objective is

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Prohibition may have had untoward social effects, but it did reduce alcohol consumption. Its repeal has produced a sustained rise in cirrhotic deaths

laudable, I question the validity of the approach. It's precisely the countries that introduce children to alcohol at an early age—France and Italy are good examples—that have the highest death rates from cirrhosis of the liver.

The approach is also somewhat strange. It would be difficult, for example, to imagine a Cooperative Commission on the Study of Tobacco Addiction, consisting of leading figures in medicine and public health, who would adopt as one of their major goals to "assist young people to adapt themselves realistically to a predominantly 'smoking' society," and who would urge that individuals be introduced to cigarettes early, within the family, so they may learn to smoke in moderation.

In 1973, cirrhosis of the liver was the seventh leading cause of death in the United States, but only four years earlier, it was ninth among the causes of death, and four years before that, in 1965, it did not even appear among the nation's 10 leading causes of death.

The cirrhotic death rate has had an interesting history. From 1900 to 1914, it varied between 13 to 15 per 100,000 population. It dropped sharply during the first World War to a low of seven in 1920, remained at

seven for 14 years, through 1933, and then began the continuing uphill climb which brought it to its high-point in the 20th century, 16 per 100,000 in 1973.

How can we account for these variations? Fortunately, data are available on alcohol consumption for all years except the period of prohibition, and we find a striking parallelism between the per capita consumption of alcohol from spirits and wine and the cirrhotic mortality rate. As per capita alcohol consumption rises and falls, so does the cirrhotic death rate.

The fall in the rate during World War I was associated with a drastic decline in alcohol consumption as a result of effective wartime prohibition. Was civilian prohibition also effective? Current mythology holds that it was not. The fact that the cirrhotic mortality rate stayed at seven from 1920 through 1933, and began to rise immediately thereafter, indicates that the mythology is probably serving other interests than the truth. Prohibition had untoward social effects such as racketeering and crime, and it was clearly ineffective in maintaining popular support sufficient to prevent repeal. Nevertheless, prohibition had considerable success in maintaining alcohol consumption at the level to which it had been reduced in World War I. The sustained rise in the cirrhotic death rate since the repeal of prohibition has paralleled a continuing rise in alcohol consumption in the United States.

The British Experience

The United Kingdom has never adopted prohibition. Nevertheless, their success in preventing alcoholism and its consequences has been quite remarkable.

During World War I, the British were beset by lagging production in industry, especially in shipbuilding. A major factor was alcoholism. Three measures were taken: First, grain was no longer made available for the manufacture of alcohol, since, in any case, it was needed to feed the population. Second, the hours of sale of alcoholic beverages were drastically restricted. Third, the price of alcohol was sharply increased through taxation. As a result of these measures, the cirrhotic mortality rate fell from 10 per 100,000 population in 1911 to five in 1920.

With the end of the war, the restrictions on alcohol production were lifted, but the hours of sale were never



restored to their pre-war magnitudes. Some increase was granted, but only to about half the pre-war hours. Most important of all, the high taxes on alcoholic beverages were not rescinded. On the contrary, they were increased, and continued to be increased over a long period of time. As a result, the price of spirits rose more than fourfold from 1918 to 1936, and consumption declined by two-thirds in England and three-fourths in Scotland. The cirrhotic mortality rate for the U.K. was three in 1936, and the latest available figure for 1971 is still three per 100,000.² From 1914 to 1971, the U.K.—without prohibition—reduced the cirrhotic mortality rate by 70 percent and undoubtedly greatly lowered the incidence of other diseases associated with alcohol consumption. During the same period, the U.S. went from prohibition to repeal and ended with a cirrhotic mortality rate—and an alcohol problem—of greater magnitude than when we started out in 1914. (Our efforts throughout this entire period might well be described as 60 years of dismal failure.

Other Countries

The relation of cost, consumption and cirrhosis is not an isolated or purely British phenomenon. Canadian research workers have shown that both for the province of Ontario, and for Canada as a whole, in-

creases in the relative price of alcohol are accompanied by lower consumption and lower mortality rates from cirrhosis. When alcohol is relatively cheap, on the other hand, both the amount that is consumed, as well as the death rate from cirrhosis, go up.

Research workers at the Addiction Research Foundation of Ontario have prepared the following table, which demonstrates that these relationships are not an aberration of the English speaking countries. It also demonstrates that price is not the only factor involved. As the authors point out, two aspects must be taken into consideration: the relative price of alcohol and the level of acceptance of drinking in a society. In general, low relative price is associated with high alcohol consumption and a high cirrhotic death rate. A notable exception is the Netherlands, where there is comparatively little tolerance for heavy drinking, particularly among the Calvinists of the rural north. High relative price appears to be almost always associated with low alcohol consumption and a low cirrhotic death rate. Czechoslovakia may be an exception to this rule. Ireland, despite the popular image is not. Indeed, the power of price is nowhere more evident than in the land where, despite the traditional acceptance of drinking, consumption is low and cirrhotic deaths are few, as compared to many other countries.

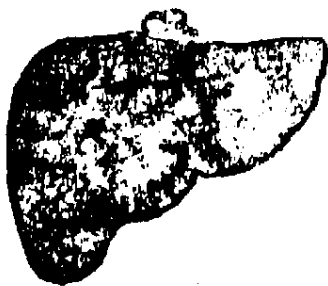
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**COST OF BEVERAGE ALCOHOL, CONSUMPTION
AND LIVER CIRRHOSIS MORTALITY IN VARIOUS COUNTRIES.***

COUNTRY	ALCOHOL CONSUMPTION ¹	RELATIVE PRICE ²	DEATHS FROM LIVER CIRRHOSIS ³
France	24.66	.016	51.7
Italy	18.00	.027	30.5
Portugal	17.57	.023	48.0
Austria	14.47	.025	38.5
West Germany	13.63	.026	29.0
Australia	10.71	.029	7.8
Czechoslovakia	10.27	.080	14.8
Canada	8.95	.029	11.6
Belgium	8.42	.022	14.2
United Kingdom	7.66	.057	4.1
Rep. Ireland	7.64	.092	5.0
Denmark	7.50	.069	11.6
Netherlands	6.19	.028	5.7
Finland	4.16	.117	5.4

* From chapter by Robert E. Popham, Wolfgang Schmidt and Jan de Lint, in forthcoming publication by Nelson-Hall, Chicago: Law and Drinking Behavior, Edited by J. A. Ewing and B. A. Rouse

¹ Liters of absolute alcohol per capita aged 15 and older (years 1966 or 1967). ² The cost of 10 litres of absolute alcohol divided by personal disposable income. ³ Per 100,000 aged 20 and older



Alcoholic beverages should be taxed according to their alcohol content. In fact, I believe an ounce should cost five times more than at present

A Program for the United States

To be successful, a program for the prevention of cirrhosis of the liver and other diseases associated with alcohol must be based on the epidemiological concept of agent-host-environment interaction. Prohibition has proved that it is extremely difficult to remove or destroy the agent; and unfortunately, there is no immunizing procedure to protect the host. Only one alternative is left: to create environmental barriers between agent and host, a method which has been most effective in preventing cholera, typhoid fever, infant diarrhea, malaria, and occupational and other diseases.

One of the essential barriers is educational. All negative education—that is, advertising of alcoholic beverages—should be banned. Emphasis here should be placed on the word “all.” We have learned from the action taken on cigarettes that stopping radio and television advertising results in a shift to magazines, newspapers and other available media. The positive educational program needs to be a serious one, for two reasons. First, tokenism is a waste of time here as in other aspects of our national life. The program has to be effective, and this means the continuing expenditure of many millions of dollars over a period of many years. Second, the program needs to make up a good part of the loss of alcohol advertising revenue by newspapers, magazines and other media, thereby helping to prevent unnecessary opposition.

The most important barrier between agent and host is the one which has been shown to be effective in other countries. Alcoholic beverages should be taxed on the basis of alcohol content, to the point where the cost per ounce of alcohol is about five times the cost at the present time. This action needs to be coupled with a program of subsidies and technical aid to farm-

ers to prevent economic hardship, help them shift to other crops or divert their crops to other uses. Similar subsidies and technical assistance should be provided to alcoholic beverage companies where needed, in order to permit them to diversify and change to other products in order to soften the economic impact.

The Question of Freedom

There are many individuals who object to any such program on the grounds that it interferes with individual freedom. Indeed it does. It should be noted, however, that the degree of interference is much less than our freedom-loving forebears in the 19th century were willing to accept for the sake of health. After all, when a city installed a safe water supply, it was never done with the consent of all the citizens, and it cost them a great deal in taxes. Furthermore, their personal freedom was seriously restricted: They were actually forced to drink the pure water that came out of the faucet instead of exercising freedom of choice among the various polluted or potentially polluted wells in the neighborhood. To be sure, they did have the right to ignore the faucet and either walk or drive their carriages beyond the city line to partake from a tasty and probably polluted well out in the country.

Again, compulsory pasteurization of milk was accepted and implemented as a valuable public health procedure in the first half of the 20th century, despite the fact that it interfered much more drastically with individual freedom of choice than the proposed program for alcohol control. Consumers could no longer buy raw milk, even though, as everyone knew, it tasted better than the “unnatural” pasteurized product.

The freedom argument is a bit thin. Everyone in Great Britain is free to buy and consume as much alcohol as he wishes. His choices are made, however, within a different societal framework than ours, one which apparently values life and health more highly. Members of the medical profession in our country will need to examine the evidence carefully and give serious consideration to the fundamental issues involved. A fundamental observation is that clichés may save thought, but they will not save lives. END



Milton Terris, M.D. (N.Y.U. College of Medicine, 1939), is Professor and Chairman, Dept. of Community and Preventive Medicine, N.Y. Med. Coll.; and Coordinator, Faculty Institute on Med. Care Teaching, Univ. of Mich.