

# HEALTH\* PAC

HEALTH POLICY ADVISORY CENTER

**Bulletin**  
March 1970

*Editorial. . .*

## THE MALE-FEASANCE OF HEALTH

IN WASHINGTON, DC, WOMEN DISRUPTED SENATE HEARINGS ON THE SAFETY OF BIRTH CONTROL PILLS, DEMANDING THAT WOMEN BE ALLOWED TO TESTIFY. IN CHARLESTON, SOUTH CAROLINA, WOMEN HOSPITAL WORKERS LED, AND WON, A BITTER STRIKE FOR UNION REPRESENTATION. IN CHICAGO WOMEN HOSPITAL WOKERS JOINED WITH WELFARE MOTHERS' GROUPS TO DEMAND BETTER TREATMENT FOR WOMEN WORKERS AND CONSUMERS IN THE HOSPITAL. AND IN NEW YORK CITY, 400 WOMEN ARE SUING THE STATE OF NEW YORK FOR INFRINGING ON THEIR CONSTITUTIONAL RIGHTS THROUGH LAWS PROHIBITING ABORTIONS.

The American health care system is a disaster for almost everyone who tries to use it. All consumers face continually escalating prices for services which are increasingly fragmented, depersonalized and just plain hard to find. All health workers face a rigid, doctor-dominated hierarchy, where all but the top jobs are low-paid dead-ends. But certain groups are especially oppressed by the American health system, both as workers and as consumers. Black and brown people suffer not only because they are poor but because of the built-in racism of most medical institutions. Less appreciated, but potentially just as explosive, is the specific oppression of women—of all classes and races—by the health system.

To start with, women are much more dependent on the health system than are men. Women consume the bulk of America's health services: They make, on the average, 25 percent more visits to the doctor per year than men, and more than 100 percent more if mothers' visits to take their children to the doctor are counted. Women consume 50 percent more prescription drugs than men, and are admitted to hospitals much more frequently than men. As workers, women have always depended on the health system as one of the few places where a woman could always find a job. About 70 percent of all health workers, and 75 perecnt of all hospital workers, are women. Thus whatever goes wrong with the health system is a problem, by and large, for women.

As in almost every other institution of American life, however, it is men—doctors, medical school deans, hospital directors and trustees, and drug and insurance company executives—who make the decisions. Men decide which jobs will be available to women health workers, how much they will be paid and even what kind of uniform they will wear. For women health consumers, men decide on the most personal issues of health care—what form of birth control a woman should use, whether she should have an abortion, what method of childbirth she should use, and of course, how much she should be told about the risks and options. In their exercise of power over women, men in medicine are no more objective and scientific than any other men. They start with an irrational image of women as ignorant and passive dependents of men, and they reinforce that image in every aspect of the health system.

For women health workers, this means being type-cast into jobs which are subordinate and subservient to men. Throughout the health system, men occupy the scientifically interesting, or authoritative, positions; women do the scut work. Women, not men, are nurses, not because women are more "nurse-like" than men, but because from grade school on, women are encouraged to aim no higher than nursing. Women are not encouraged to take science courses in high school and college, and they are

## Women In Action

**PAST BULLETINS HAVE TRACED the development of community, health worker and student movements for high quality, accountable health services. This BULLETIN takes a look at the issues which are now propelling women into action against the over-priced, inadequate—and male-dominated—health system. Two guest writers contributed to this BULLETIN—both activists in the New York women's liberation movement.**

actively discouraged from entering medical school. Nursing itself is supposed to be a specifically feminine occupation, requiring no initiative or ability to reason. And as one medical school dean put it, "The reason that nurses are all women is that men couldn't put up with the kind of relationship that a nurse has to doctors." The doctor-nurse relationship is always authoritarian, and often characterized by subtle or overt sexual manipulation of the nurse-handmaid.

Even the women who enter the more "masculine" occupations of technicians, administrators or physicians do not find equality. Category by category, women earn 10 to 15 percent less than men in the same job. And the few women who become physicians (only seven percent of American physicians are women) are primarily concentrated in the lower-prestige, lower paying specialties, especially pediatrics, rather than the "high-technology" specialties, such as surgery.

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## Women As Health Workers

# THE LADY'S NOT FOR BURNING

LOWER EAST SIDE, NEW YORK JANUARY 1858: Dr. Edith Blackwell and Dr. Marie Zahrzawska opened one of the first nursing schools. The women had fought for many years to raise money to start a clinic and then to open a complementary school of nursing. They got meager support, especially from the medical profession. Doctors claimed that women could not be trusted to run a clinic and school without supervision from male physicians. Moreover, since nurses were going to be working with male doctors, they should be trained by men, the doctors argued. As the two women doctors struggled and succeeded in keeping their nursing school afloat, they began a fight that is still going on today: securing a legitimate place for the nurse in the male-dominated

medical profession.

The fight to gain status for nursing has been going on now for well over a century. To nursing strategists this goal has always been a determining factor in their relationship to the rest of the medical world and their struggles within the nursing profession. For instance, nurses' traditional feud with doctors is based on the nurses' feeling that doctors do not recognize them as professionals, but only as handmaidens for the MD's. Anyone who works in a hospital setting understands that the perceptions of nurses about doctors have much validity. But nurses are becoming increasingly independent and the waters ahead seem quite stormy.

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## Editorial

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Women as health consumers are oppressed by the same male supremacist attitudes and institutionalized practices which oppress women as health workers. When they enter a hospital or a doctor's office, women encounter a hierarchy dominated by men, in which they see women playing only subservient roles. Then, as patients, they encounter all the male supremacist superstitions which characterize American society in general. Women are assumed to be incapable of understanding complex technological explanations, so they are not given any. Women are assumed to be emotional and "difficult," so they are often classified as "neurotic" well before physical illness has been ruled out. (A glance at the tranquilizer ads in medical journals shows that women are, in the drug companies' view, the heaviest consumers.) And women are assumed to be vain, so they are the special prey of the paramedical dieting, cosmetics, and plastic surgery businesses.

Everyone who enters the medical system in search of care quickly finds himself transformed into an object, a mass of organs and pathology. Women have a special handicap—they start out as "objects." The sick person who enters the gynecology clinic is the same sex as the sexual object who sells cars in the magazine ads. When it comes to dealing with women's bodies, physicians are no less likely to be hung-up than other American men. What makes it worse is that a high proportion of routine medical care for women centers on the most superstition and fantasy-ridden aspect of female physiology—the reproductive system. Women of all classes almost uniformly hate or fear the gynecologist. He plays a controlling role in that aspect of their lives society values most—the sexual aspect—and he knows it. Middle class women find a man who is either patronizingly over-jolly, or cold and condescending. Poorer women, using clinics, are

more likely to encounter outright brutality and sadism.

Women's encounters with the health system do not end with their own health needs. In this society women bear the chief responsibility for the health of their children. Wherever the health system is inadequate or inaccessible, it is up to the mother to fill in. Even when the mother succeeds in substituting for the failing health system, she has to contend with continually proliferating household hazards. Drugs and food additives are only perfunctorily regulated by the Food and Drug Administration: It is up to the mother to determine whether monosodiumglutamate, or before that, cyclamates, are harmful for infants, and to choose among a dozen brightly advertised, but potentially dangerous cough syrups or eye drops or lotions.

The hospital workers, mothers and young women consumers who have begun to challenge health care institutions know that health is only one among many issues that women must face in their struggle for equality and self-determination. Male supremacism runs as deep in our society as racism, governing the way we are educated, entertained, employed and ultimately determining the ways we see ourselves and other people. It cannot be uprooted from the health system without changes in every social institution which now oppresses women—from the family to the major corporate bureaucracy. If so many women are turning first to health institutions, it is because that is where they are—as workers, as patients, as mothers.

For the health system, the onslaught of women's insurgency could have a revolutionary impact. Women are strategically placed within the health system, holding most of the jobs and using most of the services. As consumers, the very nature of women's dependence on the health system (chiefly for preventive care for themselves and their children) is a strategic advantage: Women, more often than not, are **healthy** when they confront the health system. As workers, women have been consistently denied positions of administrative or professional authority, so that for most women workers there is little barrier of "professionalism" to prevent them from taking action around their demands. Finally, the institutional and attitudinal sources of oppression are the same for both women workers and consumers. Already there are the first signs of an alliance between women workers and consumers—an alliance which will shake the male-dominated health system to its foundations. D

Many nurses have long believed that the solution to their problems is "professionalism." As defined by nurses, professionalism has two aspects. First it means a separate, well defined niche for nurses, independent from and equal to MD's, and clearly set off from the less skilled members of the hospital staff. Second, professionalism, to nurses, expresses the hope that nurses can make more significant contributions to excellent patient-oriented care. No one can question the nurses' goal of improved patient care but many personnel in hospitals and schools are opposed to putting the nursing profession on a par with the medical profession. The doctors, hospital administrators and medical educators see nursing professionalism as expensive and personally threatening. The less skilled hospital personnel also feel threatened by it. They see it as widening the gap between the aides, orderlies, etc. and professional nursing, making upgrading more and more difficult. Finally, some critics believe that "professionalism" for doctors as well as nurses, may actually be an obstacle to improved patient care.

The history of nursing in the United States begins in two very different settings: on the Civil War battlefield and on the streets of the immigrant urban ghettos in the early 20th century. Miss Dorothea Dix, with the help of many other brave women, set up the Sanitary Commission of the Union Army. Though she had to fight the Army Medical Corps all the way, by the end of the war the Sanitary Commission consisted of 7,000 local chapters and had spent \$50,000,000. Not only did these women knit, sew and roll bandages for the union forces but some of them worked very close to the battle fronts, bandaging the wounded, carrying water, maintaining hospital ships and convalescent homes.

### **Postwar Public Health**

After the war, the next development was public health nursing. Many women continued to use the skills they had learned during the war in their home cities instead of on the battlefield. Wealthy urban women began to provide nursing service in poor neighborhoods as a contribution to charity. Over the years, many more women, not all of them rich, extended this work beyond the urban ghettos to middle class neighborhoods. Public health nursing was used as a major way of disseminating information about preventive medicine.

Nineteenth century war nursing and public health nursing had a continuing effect on the development of careers for women. Women learned through them how they could work together, what kind of impact they could have and also that their role was essential to good health care. The development of nursing coincided with the growth of the women's rights movement and played a very important role in bringing about independence for women. Women understood that the right to hold property legally, the right to divorce, and the right to vote were only paper gains if women could not participate in the working of the economic, political and social system of the society. For many women, especially those of middle class origin, the road to independence was nursing, an extension of their role as wives and mothers.

Despite its role in shaping nursing as a career, public health nursing did not continue as the dominant direction of nursing. By the 1920s it had become clear that nursing was going to be a predominantly hospital based job. As the hospital became the most important institution of the US health care system it was quite logical that the bulk of nurses

would work there. And since the growing importance of hospitals was tied to the growing medical technology, nurses, with less scientific training, were seen as doctors' helpers. It was becoming increasingly clear that doctors were the most important members of the hospital staff and that the nurses could only be subordinate.

The struggle to define the professional role for nursing has been spearheaded by the two important nursing organizations. The National League for Nursing (NLN) (originally the National League for Nursing Education) has undertaken to promote nursing education. It originally included in its membership doctors, hospital administrators and interested laymen as well as nurses, but the league rapidly became the organization of the nursing educators—the nursing elite—and of the "lady bountifuls" associated with the public health agencies. The NLN is the credentialing body for nursing schools and has much influence over the state licensing procedures.

The second organization for nurses, the American Nursing Association (ANA), has been the traditional nurses' organization. In the past it has been overshadowed by the NLN but in recent years it has grown rapidly. Since the 1940's, the ANA has taken the lead in developing programs around economic security and education for nurses. The NLN has lagged behind. Consequently in the last several years there has been much conflict between the ANA and the NLN. Though the NLN still retains considerable power through its role in accrediting nursing schools, it seems clear now that the ANA will be the dominant force in setting nursing policy in the future.

The ANA's strategy has been to "professionalize" nursing education so as to create a nursing educational system that resembles the medical school system in its form and outlook. But many young nursing school graduates are finding that this new emphasis has to some extent limited their ability to provide good patient care.

In June, when 40,000 nursing school graduates get their first jobs in hospitals, they will very quickly find out that their jobs do not live up to expectation. The young woman has been told by her educators that as a modern nurse she will, upon graduation, work as an independent professional having direct effect on patient care—with an emphasis on the whole person. She has been told that she will play a leadership role towards the non-professional staff, and her aspirations to continue her education will be worthwhile and essential to her development as a nurse.

The reality is quite different. Once in the hospital the nurse understands that in fact she has little to do with direct patient care and that it is of no matter to anyone if she thinks of herself as an "independent professional." Just to keep patients alive she must race around the hospital delivering test results, doing paperwork, repairing broken equipment and assisting the interns and residents. After all that she has no time left to consider "the whole patient." And all the theoretical skills she has learned in school are often of little help. One nurse, working in a mid-western county hospital, learned rapidly that the lowly nurses aides often were more skilled than she was. "It took me almost a year just to learn the basic nursing skills I had not learned in my fancy nursing school." Instead of the nurse being the captain of the team, she realized that in fact she was the slowest runner.

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Another young nurse, who decided she could best express her professional independence by getting a job outside of the hospital setting, was also disillusioned. Before graduation she secured a job in a drug addiction program and was much encouraged when she found out that she was not even required to wear a uniform. She was told that her job would entail continuous, close contact with the participants in the program. In fact, all she did was dispense methadone medication once a day. Instead of being undertrained, as the hospital nurse found, this nurse felt she didn't need any education to do what she was doing. "I didn't even have to know what drug addiction was to give out methadone. It could have been plain orange juice [methadone is dispensed in orange juice] and it wouldn't have made any difference to the work I was doing."

## Professional Frustration

Nurses' expectations of equality with other health professionals are also frustrated. The nurse receives a relatively low salary, little status and frequently performs jobs way below her training level. Under these conditions she has a difficult time understanding how more education will help her at all.

Frustrated by these disappointments, young nurses are growing more militant. Though the nursing leadership claims things are getting better and the future for nursing is bright, the young nurse is finding little solace in these assurances. "I think nursing has been slapped around long enough," says one nurse. "I find that professional leaders in nursing actually limit nursing to a certain fixed role," charges another.

Many of the young nurses of today are being trained in a different fashion than their older colleagues. Though 80 percent of all practicing nurses are trained in hospital based diploma schools, the trend in nursing education is toward academically oriented Junior College or Baccalaureate programs. Diploma schools are closing at the rate of about 100 a year because they lack funds and teaching staff. Colleges and universities are opening nursing schools to fill the gap.

The shift towards academic nursing has had profound effects on the kind of training nurses receive. In the older programs, future nurses learned by actually performing hospital procedures. Anything else they learned largely by rote. There is little place for conceptual understanding in the diploma school curriculum. Most of these programs are inexpensive because the students provide free labor to the hospital they train in. In the new academic programs theoretical nursing concepts and basic science are the major emphasis. At most degree (academic nursing) schools the first year is similar to first year medical school, with the addition of a course on nursing theory.

In practice, the new academic emphasis creates a new hierarchy within nursing. Replacing the hospital-based diploma school will be two programs: the Associate of Arts Degree (AA) Program and the Bachelor of Science (BS) Program. Women graduating from the BS program will be "professional nurses" with training in team leadership and nursing theory. The AA nurses will be trained to do the kind of scut work now done by practical nurses and by staff nurses who have graduated from diploma schools. In urban settings, black and

brown women who have gone to ghetto high schools and lack an academic orientation will at best go to nursing schools offering the AA program. In other areas of the country, the AA programs will provide training for some rural poor who see nursing as a way of breaking out of poverty. The BS program, on the other hand, will attract chiefly middle-class women. The nurses who graduate from AA programs will become Licensed Technical Nurses with lower salaries and non-supervisory jobs. Nurses who have BS degrees will be "professional" nurses with higher "professional" pay.

The new trend in nursing education fits very nicely with the push for professional independence on the part of the ANA and the NLN. Freeing nursing training from the doctors by emphasizing academic excellence and theory instead of practice gives a much greater potential for professional status. Since the NLN is the federally recognized accreditation agency and a school cannot receive government funding without NLN accrediting the nursing hierarchy holds some very important trump cards. But at the same time it undercuts the value of training by practice. Most workers in the hospital setting, from aides to hospital administrators, say that academically trained nurses, whether they be AA or BS nurses, do not have the skill to do competent hospital work upon graduation. The women who are now providing nursing care in hospitals are bitter because the new system bypasses them. The response of many diploma nurses has been to struggle to get enough academic college credits to receive BS degrees. Others, who do not have the opportunity to do that, are beginning to question the new trend. "I'm just as good a nurse, if not better, than a nurse with a BS degree," says one practicing nurse with a diploma degree, "and I'm not going to let those academic nurses push me around."

The push for academic education is finding some powerful adversaries outside the nursing profession. The medical schools, the American Hospital Association and the AMA have all come out against the shift away from diploma schools. The AMA has argued a predictable position. Doctors say that nurses only have to know how to do procedures; they don't have to know why they are done. Doctors are the ones who should know why. And in their estimation the best way to learn is by repetition. The AHA sees in the change a loss of the cheap, if not free, labor they got from nursing students in diploma schools. They also argue that the more educated nurses become, the more money they will expect—giving another boost to hospital labor costs. The AMA, the AHA and the medical schools are all threatened by the possibility of nurses becoming so skilled that the barriers between the male profession of doctoring and female role of nursing break down.

## Deans Wage Struggle

Recent events at UCLA suggest that the doctors, hospital administrators and the medical school deans are fighting a losing battle against the trends towards academic nursing. In 1969 the dean of the UCLA Medical School attempted to convert the UCLA Nursing School from a BS to a diploma program because he thought he would have more influence over a diploma program. The dean of the UCLA Nursing School had consistently taken an independent stance towards the medical school. She hired a very young, aggressive faculty to teach nursing subjects with a "professional" tone and at the same time debunk the medical profession. In addition,

she instituted curriculum modifications de-emphasizing routinized learning. When the nursing school dean decided to retire, the dean of the medical school proposed the diploma program so he might have an opportunity to closely direct nursing education at UCLA. The medical school dean met with opposition from nursing deans, professors and students, from all over the country. The NLN took a very strong stand in favor of the four year academic program. After months in committee the dean lost his fight. In fact the situation, from his point of view, worsened. A Doctorate of Nursing program was instituted and for the first time nursing school faculty were added to the medical center academic committees.

Not all nurses are sure that the change to academic training will help prepare nurses for patient care. The new approach to nursing education which the ANA and the NLN are pressuring for has its own serious problems. To begin with, the standard learning-by-doing techniques of nursing education is sacrificed for an emphasis on academic excellence. And even the "academic excellence" claim is somewhat of a sham. Medical students are fighting to end the overly academic orientation of medical schools because the strictly scientific approach to medicine does not help them learn about patient care. The new academic emphasis in nursing schools re-creates problems in nursing education that medical students are trying to fight.

Another disadvantage of the new educational trend in nursing is that it will rigidify the nursing profession. Academic emphasis freezes into the system of education a greater division between the LPN's, aides and other auxiliary personnel in the hospital setting. By making an academic degree (AA or BS) a necessity for advancement in nursing, many black, brown and working class white people, who are not privileged to attend college, will not be able to better their position through experience.

Academic nursing education and a belief in nursing "professionalism" cannot change the deplorable conditions that exist in many hospitals in the US. Increasingly, nurses are using strikes and job actions to press for improved conditions in hospitals rather than just traditional trade union demands for higher wages. Nurses consider other issues as equally important, such as: recognition of the ANA as their professional organization and bargaining agent; and participation in hospital decision-making especially in those issues which concern staffing patterns and patient care organization. Nurses understand that they must fight to change their status and to improve their working conditions. But this has not always been the case—nursing militancy is a new phenomenon.

On the job organizing by nurses for improved wages and working conditions has, until recently, been considered unethical by most nurses. The ANA has always discouraged nurses from joining unions, arguing that "their professional associations . . . have the instruments best fitted and equipped to improve every phase of their working and professional lives." In the late 1930's the ANA urged the state Nursing Associations to assume responsibility for setting standards of nursing care and employment conditions. Several state Nursing Associations tried to carry out such programs but they had little success.

In 1946, to control the growing discontent among nurses, and offset the threat of unionization, the ANA initiated a policy called the Economic Security Program. This program is the theoretical foundation for the most recent nurse bargaining and strike actions. The program developed a long-

## Back On The Job

- There are approximately three million women employed in the health care system. They hold 70 percent of the nation's health jobs. In each job category they earn wages averaging about 10 percent lower than those for men in the same jobs.

- The number of registered nurses employed in the entire health care system more than doubled from 1949 to 1968 (300,000 to 660,000). This increases the number of nurses per 100,000 population from 249 to 331. Employed nurses represent two thirds of all nurses holding licenses.

- 5,590, or little less than one percent of all nurses, are men.

- Of all the nurses who work, 77 percent work in hospitals; 4.5 percent work as public health nurses; 3.5 percent as nursing educators; and 15 percent as either office, school or industrial nurses.

- Supporting the 660,000 working registered nurses were 300,000 licensed practical nurses and 800,000 aides, orderlies and attendants.

- While in the hospital, the health service employees spend their time as follows: Nurses aides and orderlies spend 54 percent of their time on direct patient care (medication, treatment, personal care); 22 percent on indirect patient care (clerical, patient servicing, exchange of information); and 24 percent on employee activities (unit servicing, personnel). Staff nurses spend 51 percent of time on direct patient care; 37 percent on indirect patient care; and 12 percent on employee activities. Head nurses spend 26 percent of time on direct patient care; 58 percent on indirect patient care; and 16 percent on employee activities.

range, comprehensive strategy of collective action, designed to attract and retain nurses in the profession and improve their working conditions. Although the major instrument the ANA has used to carry out this program is collective bargaining, the ANA is most adamant in insisting that it is not a union but a professional organization. They therefore do not have a program to actively organize nurses but only to represent them when asked. To emphasize this position a no-strike resolution was passed at the 1950 ANA convention.

The ANA has implemented the Economic Security Program slowly and cautiously. Though conditions for nurses in most hospitals were deplorably bad, collective bargaining was not widely used by the nursing association until the early 1960's. When finally implemented it is questionable whether its use reflected an increased militancy of the nursing associations or whether they were using it to cool potential strike situations. In line with the 1950 resolution on the "unprofessional" nature of strikes, nurses in New York and California threatened mass resignations if their conditions were not improved. In both cases the state Nursing Associations stepped in and made agreements with the hospital authorities satisfying the nurses and thereby making job actions unnecessary. Recently, however, nurses have begun to take stronger actions against hospitals so that agreements negotiated will represent greater gains. With the advent of new insurgent feelings and pressure from the most militant state associations the ANA was forced to rescind the no-strike policy at its 1968 convention.

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(But in spite of the more militant position regarding strikes, other resolutions passed at the 1968 convention to deal with labor problems represented no change in policy. The ANA continued to favor nurses holding BS degrees by setting national wage goals for Diploma and AA nurses at \$7,500 and for Baccalaureate nurses at \$8,500.)

The story of the 44 day nursing strike in July, 1969 at Cedars of Lebanon Hospital in Los Angeles, California, illustrates the new nursing insurgencies. The strike's implications for the future of nursing are profound because it illustrates how nurses have used strike tactics to establish professional status for nursing as well as better salary and fringe benefits. Problems at Cedars of Lebanon began in 1968. Lack of communication with hospital administrators about the nursing shortage and declining nursing care standards created low morale among the nurses. The hospital administration responded by forming a Professional Performance Committee (PPC) at Cedars. The PPC was modeled after similar committees in hospitals around the country to function as a grievance mechanism for professional employees, including nurses and a limited number of MD's. This committee, after many months of meetings, presented the hospital with a modest set of demands including increased salaries, fringe benefits and some modification of procedures relating to nursing performance. Not only did the hospital refuse to accept the recommendations of the nurses but it also fired two members of the nursing supervisory staff claiming the dismissals were "in the best interest of the institution." Understanding that the hospital could not be trusted, the nurses asked the California Nursing Association (CNA) to represent them for protection.

The nurses' first act was a "nurse-in." This meant that for a selected twelve hour period vacationing and off-duty nurses worked in the hospital for no pay in order to demonstrate what nursing care, could be like with a full staff. When they received no response from the hospital, the nurses went out on strike. As the days passed the issues became clearer: "Recognize the CNA as our bargaining agent." Though the strike ended without actual recognition of the CNA, the contract contained other important new provisions. An elected Nurses Committee was established to meet regularly with representatives of the nursing office and the hospital administration to discuss patient care issues, staffing patterns, personnel matters and other issues. Another part of the agreement made it possible for the Nurses' Committee to meet with the CNA on hospital time. In the standards of the nursing association this was a very important provision because only people with professional status can use their working time for other business.

## Women Strike Back

The Cedars strike is not the only example of the new trend in nursing negotiations. For example, nurses at the Freedmen's Hospital in Washington threatened a strike last November because the nurses were forced to take on what they felt were "ethically dangerous assignments" such as covering two wards at once. The strike was averted because the hospital agreed to negotiate with the D.C. Nursing Association on matters of "professional working practice."

The ANA believes that the demands set forth by their state affiliates are beginning to improve the status of nurses. Though the number of strikes have been few, they have affected nursing care all over the country. Increased salaries have helped nurses, but also made nurses too expensive for hospital scut work, therefore increasing the division between nurses and non-professional personnel who do the dirty work. Increased involvement in decision-making on an administrative level has gone a long way to create the illusion of professional status. The ANA feels that these gains will encourage more women, and hopefully more men, to enter and return to the nursing profession.

The May editorial in the American Journal of Nursing expresses their hopes best:

*It is just possible that the controversial subject of collective bargaining, which has been dividing nurses for years, will become a primary means for achieving that elusive professionalism. And it could even be a unifying force for the profession.*

But it is questionable if positions on administrative committees and professional privileges will help the majority of nurses who work in hospitals. Staff nurses question the value of these gains. In the words of one nurse, "Professionalism doesn't help us, it only helps those nurses who hold positions at the top of the hospital structure."

Job actions and changing educational patterns have not been enough to make fundamental changes in nursing. There are several plans proposed by nurses holding administrative positions in nursing to make the job of a nurse radically different than what it is today. These changes are designed to further define the professional status of nursing and also to help alleviate the personnel shortage. Whether they in fact do either is questionable. The three most popular plans are the nurse-clinician proposal, the masters degree program, and the "Duke plan."

The nurse-clinician proposal is an attempt to free nurses from the now overburdening administrative task they must perform. As nurses gain more and more experience, their career ladder takes them further and further away from the patient.—For example, a staff nurse spends 50 percent of her time in direct patient care while a head nurse spends only 25 percent of her time with patients [see Box, Page 5]. The nurse-clinician would have no administrative duties. She would assist in and (depending upon her level of advancement) direct the care of patients. A new job category would be created to perform the administrative duties—the Unit Manager, who would work hand in hand with the nurse clinician to provide quality care.

Masters Degree and Doctorate programs in nursing are springing up all over the country as another solution to nursing problems. These programs partially provide teaching personnel for the new Associate Degree and Baccalaureate programs but also provide a new level of specialization for nurses. They produce nurses with clinical skills similar to doctors', but without diagnostic and other technical skills of MDs. For example, the nurse-pediatric program (a MA program in several schools around the country) educates nurses to provide basic pediatric care for any child. In fact this program educates the nurse to do all procedures and deliver the same quality of care as a pediatrician. But she cannot treat severe illness and must refer the child to an MD for that kind of care. This kind of program also exists in obstetrical care—nurse-midwifery—with the only limitation

## *A Matter Of Choice*

# WOMEN DEMAND ABORTION RIGHTS

LAWS OUTLAWING ABORTIONS have been in force since the early nineteenth century. At one time, when 30 percent of the people who underwent operations died of infection, abortion laws may have been a valuable protection. But now the death rate from illegal abortions is 50 to 100 per 100,000 operations, while that from legal abortions using modern methods and antibiotics is less than 3 per 100,000.

The laws have not been repealed yet because certain religious and social groups see them as crucial to maintaining public morality. However, the laws have never been fully enforced, and their existence has served only to permit those with medical power to intimidate women who wanted to end a pregnancy. The laws have given some doctors the opportunity to make huge profits off of women's needs and at the same time have given the Mafia their third most lucrative racket. In addition, they've given doctors an excuse for failing to confront their women patients as human beings with specific medical needs, allowing them to treat women as dependent and wayward children or as too-fecund sexual animals. They've given psychiatrists and social workers the opportunity to investigate, probe, sneer and degrade. And they've destroyed

being that the nurse midwife cannot deliver babies because of state laws about medical practice.

The Duke plan was designed by the nursing faculty and staff at the Duke University Medical Center. Even though this plan has not been put into effect because of opposition from the doctors and hospital administrators, it will probably become a reality sometime in the future. Under the plan the professional nurse (BS or MA graduate) would serve as a nurse-coordinator directing all patient care. LPN's or associate degree nurses, working under nurse-coordinator supervision, would handle medications and other routine work. The LPN's would work basic eight-hour shifts, while the nurse coordinator would work and be payed on a patient load basis. Each nurse coordinator would be responsible for 15-20 patients and she would plan their care with the physician. The co-ordinating nurse would be there when needed, just as doctors are supposed to be. This plan is designed to reduce the number of nurses actually needed at the present time. There would be a clear division of labor between physicians, who diagnose and treat patients' illnesses, and nurses who would provide care for the sick as both patient and person. And most importantly, it would allow the nurse to function as her education supposedly merits—as a professional with authority, skill and responsibility. Those who suggest this plan say it will begin to resolve an important problem in hospital care, the depersonalization of the patient.

What will happen to nursing care in the future is impossible to predict. One thing is clear, the proposals that have been suggested do not really strike at the heart of the problem. Nurses have traditionally fought and seem to be winning many battles with doctors and hospital administrators. They have struggled to gain an identity of their own and that goal is certainly a laudable one. But nurses must examine carefully on what terms these victories are won.

If the suggested shifts for nurses become reality, they have the potential of placing the nurse in the same league

many a woman's sexual life and have reinforced her role as man's dependent. Even now when public and professional support for changes in the laws is very strong, individuals and institutions continue to harass and intimidate, refusing women the abortions they need.

Part of the work of the women's liberation movement in New York City has been to try and discuss abortion with doctors and hospitals. While many individuals agreed that women have a right to abortion on demand, most doctors and hospital administrators indicated that they interpret the present abortion laws in the most conservative manner possible. After all, the view expounded by the most widely used text book on obstetrics (*Obstetrics* by Eastman and Hellman, 1966) is that "medical ethics do not permit abortion for sociologic reasons" and this view has clearly carried beyond student days. Many hospitals refused to discuss abortion with women at all, claiming that there was no reason why they should discuss abortion with "just women," or that they were "too busy" or "not interested."

To obtain an abortion in a hospital in New York State a  
(Continued Page 8)

with other medical professionals. But at the same time these solutions threaten to recreate the same problems that exist with doctors. First, nurse clinicians and the MA programs begin to create nursing specialists who are concerned with only one aspect of a patient's medical problems. Secondly, the concept of "professionalism" creates the same kind of mystification that makes it possible for patients to follow doctors' orders even if the patient thinks he is wrong. Thirdly, there are also no proposals suggested by the nursing leadership for advancement through experience. Educational requirements for specific job classifications tend to rigidity the system and make it impossible for people with job experience to advance, which leaves millions of workers in dead end jobs.

Nurses have correctly pointed out that the opposition to their improved status is hospital administrators, medical schools and doctors. The trend has been for nurses to demand and fight for equality with those professional forces in order that nurses themselves can play a more important role in the decision-making in the hospital. This approach, however, separates nurses further from the larger group of non-professional hospital workers who also have an interest in changing the decision-making and staffing procedures in the hospital. These workers, the aides, the orderlies, the LPN's, are in fact the people in the hospital who spend most of their time on direct patient care. They are also mostly women fighting the same male supremacy in the medical system that the nurses are. [See Box on Page 5.] Some nurses are beginning to see that to gain the strength they desire it would much better serve their interests to work with the non-professional personnel, instead of fighting for a niche in the hospital hierarchy. Already, in such organizations as Medical Committee for Human Rights, on a local and national level, nurses are beginning to work together to create better conditions for themselves and their patients.

—Vicki Cooper

# WOMEN DEMAND

(From Page 7)

woman has to be seen by a gynecologist, one or two psychiatrists and then by a three-five member abortion committee. This committee is generally composed of the heads of the Obstetrics and Gynecology departments, the head of Psychiatry and other high medical or administrative personnel. Given the structure of the medical profession, it is extremely rare that a woman doctor is on the committee, and there is no provision for the head of nursing or social work to be represented. These committees are not required by law but are devices set up by the institutions—ostensibly to protect themselves from prosecutions by the state, but effectively to sit in judgment over women. The disparity between the numbers of abortions performed at different hospitals shows that the social judgment of the professionals is more important than the law itself: Bellevue performed three abortions in 1966, nine in 1967, 23 in 1968 and only in 1969 did the number rise as high as 58. In 1968 Harlem Hospital performed nine abortions, Metropolitan 14, and Kings County and Downstate Medical Center between them performed 41 abortions in 1969. Some hospitals have not performed any

## *Survival of Fittest*

For a nation which purports to provide the greatest wealth of medical science in the world, the US has a strikingly bad record when it comes to infant mortality. As a nation the US is far behind other countries, even some which we consider "underdeveloped." The following figures are based on deaths per 1000 live births.

	<i>Infant</i>
	<i>Mortality Rate</i>
THE WORLD (1966)	
Sweden (ranking #1)	12.7
Netherlands (ranking #4)	14.7
Taiwan (ranking #13)	21.7
US (ranking #17)	23.7
THE NATION (1967)	
White	19.7
Nonwhite	35.9
MISSISSIPPI (1967)	
White	22.8
Nonwhite	47.4
NEWYORKSTATE(1967)	
White	22.8
Nonwhite	36.9
NEW YORK CITY (1966)	
Kips Bay (all white)	16.0
Washington Heights (majority nonwhite)	23.0
Central Harlem (nonwhite)	43.0

The availability of prenatal care is probably the single most important factor in preventing unnecessary infant deaths. Even many middle-class women receive no prenatal care during pregnancy or receive it too late: 12 percent in Westchester County; 13.3 percent in Kips Bay; 36.4 percent in Central Harlem; and in Mott Haven, 39.9 percent. A random sample of 90 obstetricians and gynecologists in Manhattan shows that 70 had offices in high income areas (Park Avenue, Central Park West and the East 60's); 19 had offices in middle income areas and one had an office in a ghetto area.

abortions and have also refused to treat women needing care after bungled illegal abortions. In Brooklyn, even women with spontaneous miscarriages have been refused treatment at private and voluntary hospitals and have had to resort to Kings County. Those hospitals that do treat women for the complications of illegal abortions often harass them. While most hospitals deny that they tell the police, nonetheless they threaten the women that they will and do not hesitate to further humiliate a woman who has already been through the trauma of an illegal abortion.

All over the country attempts are now being made to change the laws. Over the last few years, reform legislation has been passed in several states and considered in many more. Such laws generally allow abortion in cases of rape, incest, extreme youth, if the child is likely to be born abnormal or if the woman is suicidal. Such legislation has done little to reduce the number of illegal abortions, for at most 15 percent of cases come under the categories for legal abortions. In Maryland, under a new reform law passed in 1968, 2,100 legal abortions were performed in the last year, but this amounted to only three percent of the births during the same period and, since one pregnancy in five is terminated by abortion, a total of 12,000 to 15,000 women in Maryland must have had illegal abortions. In Colorado, where a reform law was passed in 1967, the number of legal abortions rose from 50 in 1966 to 825 in 1969, but the number of illegal abortions has stayed at around 8,000. In California in 1969, 10,000 abortions were performed legally under their reformed law, and an estimated 90,000 illegally. Since the price of a legal abortion is more than \$500 in Colorado and \$600-700 in California, the reform laws have been nicknamed "rich ladies laws."

More significant reform laws are now being introduced in several states. Washington State Senate has just passed a bill legalizing abortion on demand up to 16 weeks of pregnancy providing the woman has her husband's consent if married or her parents' consent if under 18. It is expected that this bill will meet opposition in the State House of Representatives. The Cooke-Leichter Bill being introduced in New York State would also, with certain limitations, make abortion legal if performed by a doctor. Some legislators are even prepared to push for repeal because the courts have recently been ruling that abortion laws, including reform laws, are unconstitutional.

Currently the abortion laws are being challenged in the courts in at least eight different states. The impetus for this came out of the Belous Case in California in which a doctor was convicted of illegally referring a patient to an abortionist. When the case was appealed, the decision was reversed because the only legitimate grounds for an abortion—when the "life and health" of a woman were in danger—were ruled too vague for a doctor to interpret. In September 1969, the Washington, D.C. law (also a "life and health" law) was struck down for similar reasons.

In New York State the laws are being challenged in three suits brought by doctors, clergy and welfare recipients, and in a class action brought by several hundreds of women, doctors and social workers. All four suits raise basically the same constitutional issues, though each suit gives them different emphasis. The major arguments are that the current laws are unconstitutional because they:

- Deny women their right to life and liberty in denying them the right to control their own motherhood; and deny wom-

en the right to privacy in their personal and sexual associations.

- **Discriminate against poor and non-white women**, because under the current laws the few legal abortions performed are for the benefit, almost solely, or rich white women.
- **impose on women the religious beliefs of others**, denying them a legal abortion on the basis that under religious beliefs an abortion constitutes murder of an actual person with a soul.
- **Inhibit doctors in the practice of their profession** in accordance with their best medical judgment, for the standard of a justifiable abortion is so vague that a doctor must guess at his peril whether a particular patient meets the standards.
- **Interfere with the rights of free speech** and association of all persons who wish to give and receive information concerning competent medical care for the termination of an unwanted pregnancy.

A recent decision in the case of the People vs. Robb in Orange County, California, has raised the hopes that women may win. The California reform law of 1967 allowed abortion if a woman's "mental illness" was such as to make her "dangerous to herself or to the person or property of others." In judging the case of a doctor who aborted a woman in his office, the judge ruled that the law was exceedingly vague in what it defined as mental illness, and that a doctor could not be expected to know when an abortion was legal. But the judge also ruled that a woman had the right to decide whether and when to bear children, which implied free access to contraception, including abortion. Furthermore, he stressed a woman's right to privacy in her sexual relations, indicating that the State had no legitimate interest in maintaining the threat of pregnancy as a way of controlling sexual relations within or without marriage. But the State of California, the district government of Washington, D.C., and probably New York State will appeal such local court decisions and their cases will be heard together by the Supreme Court in the fall of 1970.

If abortion does become legal, then it will become an issue to be resolved by a woman and her doctor, or more accurately by a woman and the medical institutions of this country. It is important, therefore, to try and determine what doctors' and institutions' attitudes toward abortions will be.

Recent interviews with obstetricians, gynecologists and hospital administrators give the clear impression that most doctors and psychiatrists feel that the decision to abort should lie in their hands. This despite the fact that the American Psychiatric Association and the American Medical Women's Association think that the laws should be repealed. (So far the AMA supports reform only.) For example, doctors and psychiatrists at Bellevue say they will not start performing abortions as soon as the current laws are overthrown, but will wait until new legislation is passed or until the Supreme Court has made its decision. This could mean a year's delay, a delay disastrous for many women. Many women now working for abortion law repeal feel that, if the decision as to whether to perform an abortion is left up to the doctor, women will be forced to lie, weep or act hysterically to get an abortion. "Doctors don't believe woman are rational enough to make decisions about their own lives. Why should they let us have abortions when we think we need them?" asked one of the young women working for abortion law repeal in New York.

Women in Washington, D.C. who have been attacking D.C. General Hospital for its absolute refusal to perform abortions were told that abortions were "boring" for the doctors and that births were more interesting for doctors in training. In

## Beyond The Law

The fight to get rid of New York abortion laws is moving ahead both in and outside the courts. Last November, Federal Judge Edward Weinfeld agreed that the four different suits filed in October should be heard by a three judge panel [See BULLETIN, December 1969]. Since that time, lawyers for the plaintiffs have taken public depositions from doctors, lawyers and women who have had illegal abortions. These depositions form the testimony on which the three judge panel will base its ruling. Several hundred women have attended these deposition sessions, indicating a mounting interest in the issue and in what the courts are willing to do about it. The three judge panel will hear oral arguments on April 15. No matter who wins this round, the case will probably be appealed to the US Supreme Court.

At the present time, the forces line up this way: For continued repressive abortion laws—the New York City District Attorney, the State Attorney General and a group of Catholic doctors called "Friends of the Fetus." In favor of repeal (through the legislature) and/or overthrow (through the courts)—approximately 400 plaintiffs (mostly women) and all the doctors, lawyers and others who testified on their behalf.

One of the four cases, which will be heard together, is a "class action" brought by several hundred plaintiffs on behalf of all women who have wanted abortions and all people who have wanted to give abortions or advise women how to obtain them. While the lawyers were occupied taking depositions, the women plaintiffs in this suit have been interviewing hospital administrators and doctors about their present and future abortion policies. As one after another administrator reported that even abolition of the laws will not significantly change his hospital's abortion policy, the women realized that their fight to be able to obtain abortions "on demand" must go on long after the laws are finally changed and must be brought to the doorsteps of the doctors and hospitals. On March 28, two weeks before the courtroom arguments, these women will stage a city-wide demonstration demanding free access to safe abortions for all women.

New York, doctors have said in interviews they would not be "interested" in doing many abortions. Presumably, these abortions would not be boring if accompanied by a fat fee.

Doctors claim that there would be no space in the hospitals to perform all the abortions which would be demanded if they were legal. Bellevue has said they could only double the number of abortions they are currently performing. Certainly it is true that hospitals with liberal policies on abortion are often so crowded that they have to turn away patients, but this is basically because other hospitals are doing so few abortions. But if illegal abortions do disappear, a major reason for admission into gynecological wards will go with them. In 1968 there were about 150 admissions to Bellevue for incomplete illegal abortions, about 250 to Harlem Hospital, and in 1969 about 1300 to Kings County and Downstate Medical Center. Many of these were infections requiring about four days hospitalization and sometimes surgery and more extensive treatment. About 3000 legal abortions could have been performed with this space in Kings County alone. Furthermore, since the birth rate would undoubtedly drop if abortions were available on demand, some obstetric beds would become vacant.

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## *Another Bitter Pill*

# THE BIRTH OF CONSPIRACY

IN LESS THAN 10 YEARS there has been a staggering increase in the availability of contraceptive devices. The most talked about of these has been the pill. The media, drug companies and medical establishment have advanced and profited from the myth that the pill has led to the sexual liberation of women. But nothing of the sort has happened. Women are still denied complete self-expression in this society, are still the second sex—looked at by men primarily as sex-objects. The contraceptive explosion has not extended their possible life choices in many important ways. Families may be smaller but the woman's place is still in the home. Furthermore, the continuing disclosures of many of the pill's possible side-effects makes it abundantly clear that whatever "freedom" the pill has given is greatly diminished by the risks and uncertainties involved in taking it.

The public's right to know was virtually ignored until this January when Senator Gaylord Nelson's Business Monopoly Subcommittee began calling people to the witness stand. There was ample testimony that oral contraceptives have

But the space-conscious doctors have a point. Present hospital abortions require two to three days of hospitalization. If, as expected, one million women demanded abortions every year following legalization, there would probably not be enough room in the nation's hospitals to accommodate them. The solution would be to provide abortions on an outpatient basis, as is already being done successfully in Japan and several Eastern European countries. In outpatient facilities abortions could be performed by the method of uterine aspiration (removal of uterine contents by suction), as opposed to the more complicated procedure of dilatation and curettage (D and C). All that would be required would be a few hours period of recovery and a check-up the following day.

A major incentive for developing outpatient Tacilites should be their lower costs. At present, an inpatient abortion in New York City costs at least \$600 through a private doctor or about \$300 in a hospital ward. An outpatient facility might be able to cut this to \$150. However, even this fee will hit many women hard. At this time therapeutic abortions for married women are covered by the "family plan" of Blue Cross and Blue Shield. Unmarried women cannot get the family plan or maternity coverage under other plans. It is unlikely that coverage for abortions except for "medical" reasons will continue once the laws are repealed, because with one in five pregnancies being terminated, abortion will be a very predictable (hence "not insurable") medical requirement.

The general picture for the availability of abortions will probably be as follows: In large cities some hospitals will probably eventually perform abortions on demand in outpatient facilities. Special clinics where private doctors will perform abortions with more privacy, politeness and greater cost will also be set up. Many other hospitals will perform an increased number of abortions although Catholic hospitals will never do so (12 percent of the nation's hospitals are Catholic). For the next few years most abortions will be performed by D and C with general or local anaesthetic or by uterine aspiration. Research on drugs which induce abortion, such as the prostaglandins, will probably accelerate. Outside the large cities, in the small towns and rural areas, it may

widespread metabolic effects. Dr. Louis Hellman, until recently Chairman of the Food and Drug Administration's (FDA) Advisory Committee on Obstetrics-Gynecology, and one of the pill's most ardent advocates, testified that the scope of these effects was indeed "surprising." Citing these widespread effects, several witnesses agreed with Dr. Hugh Davis of Johns Hopkins who testified that he doubted the "medical soundness" of giving healthy women "such powerful hormones to achieve birth control objectives that can be reached by simple means of greater safety." There was general agreement among the doctors that the oral contraceptive is still in the experimental stages and that much more research was needed. There was also agreement among the witnesses that to date, the FDA and the drug companies have largely failed in keeping women and doctors alerted to all the possible dangers of the pill.

All indications of possible dangerous side-effects—even when scientifically substantiated—came under the heading of  
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still be quite difficult for a woman to obtain an abortion. Women in need will probably have to travel to the anonymity of large cities. That may not seem too bad on the surface, but it will be yet another example of how women's health needs are treated in a fragmented way under the present system.

Even when abortions are easily available, middle class women who go to private doctors for their abortions will be made to feel uncomfortable and patronized. When poor and black and brown women go to the hospital OPD's, they will feel despised and degraded. Black and brown women are already afraid that their tubes may be tied without their permission or that an IUD may be inserted after childbirth or during a gynecological exam without their knowledge. (Whether these stories are true or false, they are believed.) With the acceptability of abortion, there may well be pressure put on poor black women, on unmarried high school and college students to abort rather than to bear the child.

The first problem is to get the abortion laws repealed. But many women are already looking ahead to the problems they will face even after the laws are repealed. Medical and nursing students, nurses and other health workers are beginning to ask that more abortions be performed immediately and that institutions make plans for dealing with the increased demand after the laws are repealed. Women's liberation groups who already have abortion referral services, are now urging women to go to hospitals for their abortions, to show the institutions that the demand is there and that they must face it. Some women's groups are looking ahead to the obstacles raised by doctors' and hospitals' attitudes towards abortions. "Abortion law repeal will be meaningless," said one spokesman for the repeal movement, "unless women seeking abortions are treated with dignity and respect by the doctors and hospitals. No one should think that with legal abortion, or with legal abortion on demand, or even with free legal abortion, that the women in this country will consider themselves liberated."

—Rachel Fruchter  
*EDITOR'S NOTE: Rachel Fruchter is a member of the NYC Women's Abortion Project.*

"classified" information. It took a woman, Barbara Seaman, to reveal 50 possible side-effects of oral contraceptives in her recent book, **The Doctors' Case Against the Pill**. These include sterility, heart disease, skin discoloration, nausea, depression, eye disease, urinary infections, cancer of the breast and cervix, liver disease and thrombophlebitis. An increased tendency to blood-clotting—thrombophlebitis was the first serious side-effect which came to light, breaking the spell which the drug companies and the media had created around "The Golden Pill." It is one of the few side-effects where a strong correlation with pill-taking has been scientifically determined. Another possible and especially frightening side-effect which will take years to determine is the possibility of genetic changes in the descendants of women using the pill.

Once the information leaked out, it didn't take long for women to respond. A recent Gallup poll published in **News-week** reflected more than a little disillusionment and concern: 87 percent of the women polled had heard of the hearings—according to the poll, an amazingly high percentage of awareness on a public issue. 18 percent of the women polled stated that they had recently stopped taking the pill—one third of these in response to the hearings. Another 23 percent of current pill-takers said they were giving "serious consideration" to stopping.

Until the recent hearings it was practically impossible for the average women to obtain objective information about the pill. Patient pamphlets distributed by the drug companies were simplistic and slick, completely omitting potential risks. Media coverage of the pill was favorable almost to the complete exclusion of negative research. When unfavorable studies were reported, the coverage was sensationalistic and non specific. FDA and drug companies response to such reports was that they were "non-conclusive." Everywhere we were deluged with statements from the "experts"—Guttmacher, president of Worldwide Planned Parenthood, Hellman of the FDA, Dr. John Rock, co-discoverer of the pill—affirming the pill's absolute safety. After only a few years on the market, the pill had gained what Dr. David Clark of the University of Kentucky has called "a diplomatic immunity" from criticism. "In general," wrote Dr. Herbert Ratner in the spring 1968 issue of *Child and Family*, "favorable findings of drug company-subsidized physicians, promoters of the pill and naive physicians have been encouraged, widely distributed, scientifically inflated, maximized and extolled, whereas unfavorable findings have either been ignored, suppressed, rationalized, minimized or ridiculed."

Who was responsible for this colossal cover-up? Much of the responsibility must fall on the many doctors who failed to fully inform their patients of the pill's possible risks. Even after many unfavorable reports had seeped through drug company barricades, many doctors continued to prescribe the pill without warning their patients of possible complications. And all too often, women who questioned the pill's safety were told, as Nicholas von Hoffman puts it in a **Washington Post** article, "to run along and not worry about it."

When it comes down to it, the doctor is concerned with keeping up the image that he not only knows best—he knows everything. In the words of Morton Mintz, a journalist who has carefully documented the reckless marketing and promotion of the oral contraceptive in his recent book, **The Pill**, the doctor-patient relationship is largely "built on the presumption that in medical matters the doctor knows best—that he would not prescribe the pill (or any drug) unless he

had good reason to judge that doing so was relatively safe." Furthermore, this idea that "doctor knows best" is especially important if the patient is a woman and, more especially, if she is poor, non-white or young and unmarried. Consequently, any questions which a woman patient might raise about the pill's safety challenge the doctor's sense that he knows best in medical matters—the basis for his sense of himself as a professional.

Just such a portrait of the "professional" doctor emerged recently when a woman took a pill manufacturer to court to sue for personal injuries incurred by pill use. Dr. Robert Kistner of Harvard Medical School (one of the most ardent defenders of the pill at the congressional hearings) was a star witness for the defendant, G. D. Searle, makers of Enovid. Later, partial transcripts of his testimony were read at the subcommittee hearing. When asked by counsel for the plaintiff to what extent he went over the information contained in the Enovid pamphlet for doctors with a patient, Kistner replied: "I don't relate the package insert to the patient. The package insert is related to me." When asked more specifically if he discussed the blood-clotting risk with his patients, Kistner replied that he did, if the patient herself initiated the discussion. He would not, he testified, initiate the discussion himself. When counsel for the plaintiff asked him why he didn't tell his patients of the potential risks involved in oral contraceptive use, Dr. Kistner replied: "Well, if you tell them they might get headaches, they will get headaches."

Doctors explained their nonchalance about the pill on the basis of the (supposed) excellent medical supervision of the pill-takers. In October, 1969, Dr. Herbert Ley, Commissioner of the FDA was asked if he thought that women should be better informed of the pill's known and suspected risks. Dr. Ley replied that this was unnecessary since "sufficient medical supervision is exercised." But can there be "sufficient medical supervision" in the administration of a drug about which so much is still unknown? Advocates of the pill pushed the notion that prior to a prescribing of the pill, a complete physical examination was "sufficient medical supervision." But how could it be? As Morton Mintz points out, even "the most careful and perceptive diagnostician could not on the basis of a favorable history and examination determine" if a particular woman was predisposed to blood-clotting "neither could he detect a latent cancer in the breast."

In its heyday, the pill was given to practically any women who asked for it. Very few women—private patients as well as clinic patients—received a thorough examination before they were put on the pills. Again, the advocates of the pill promoted the belief that after the pill was being taken, sufficient medical supervision meant a bi-annual checkup. And yet millions of women have their prescriptions automatically refilled every six months without even this superficial checkup. A Public Health official recently stated in an interview: "It is common practice for a woman to be given a bag of pills and told to come back in six months and then not be seen for a year. Under these circumstances it is impossible for the detailed instructions in the labelling to be followed." (Dr. Ley resigned abruptly from the FDA in December, the day after the news of the British study implicating the high estrogen pills in a greater clotting risk reached this country. He has since expressed the opinion that a pamphlet describing the known and suspected complication!

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# CONSPIRACY

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of oral contraceptives in non-technical language should be included in every pack of pills.)

A very large share of the responsibility for the cover-up job that has surrounded the pill from the start must be laid squarely on the shoulders of the drug companies. It would be difficult to conceive the amount of promotion and publicity which the drug industry undertook to sell the pill to doctors. The Prescription Task Force of HEW estimated in 1968 that the drug industry spent \$4500 per physician per year on advertising and promotion of all drugs. Plainly, this kind of money is persuasive. Furthermore, the drug industry is consistently one of the nation's most profitable. A recent article in Forbes magazine gives a partial explanation: "The drug industry has something most companies can just dream of: customers who are willing to pay almost any price for their products." In 1967, six million women took \$90 million worth of birth control pills: in 1968, the amount was well over \$100 million. Last year total sales of oral contraceptives amounted to \$120 million. G. D. Searle's share of this market was 40 percent. In 1968 net earnings of Searle (who have two contraceptive pills—Enovid and Ovulen 21—on the market) was \$27 million on sales of \$147 million—a profit of 18 percent. Whatever doubts may exist about the pill, there is no doubt that it is extremely lucrative.

As is often the case with US manufactured death-dealing devices, the pill was tested in a distant colony of the mother country. Not only were the lives of impoverished third world women viewed as unimportant, but any unfortunate accidents resulting from the drug could more easily be covered up. Enovid, the first oral contraceptive marketed in the US, was given a trial run in Puerto Rico in 1956. Of the 811 women in this study, 556 had dropped out by the end of the first year: by the end of the third not one of the original women remained. Five women in this group died from "heart attacks:" no autopsies were done. Searle spokesmen said the deaths were unrelated to Enovid. At the subcommittee hearings Dr. Edmond Kassouf testified that the possibility of blood-clotting should have been investigated in the sudden death of three of these women. He said that the Searle "handling" of this study could explain why the British were able to document the blood-clotting risk two years before the U.S.

By May, 1960 the FDA concluded that "the evidence establishes the safety of Enovid tablets" and marketing of the pill began by the end of the year. The nature of the "evidence" was not disclosed. In 1963 Senate hearings into the FDA's handling of oral contraceptives were conducted. It was discovered that the entire basis for the safety decision on Enovid was data collected on 132 women who had taken the pill for one to three years: 66 who had taken it for 12-21 consecutive cycles and 66 for 24-38 cycles. On the basis of this study undertaken primarily to test efficacy, not safety, the pill was made available to millions of women who would take it for up to thirty years. It is estimated that 132 women is fewer than the number of women who will die in 1970 from blood-clotting caused by the pill.

One of the most frequent criticisms of the drug companies expressed at the hearings was their complete failure to warn women of the pill's possible dangers. Dr. Edmond Kassouf was one of the most outspoken critics of this respect. He

testified that patient pamphlets distort or deny known risks and completely omit many suspected ones. He stated that there are still patient pamphlets in circulation which say nothing of the blood-clotting risk. (Once the FDA has compelled a change of wording in a pamphlet, it has no legal authority to demand the recall of the offending pamphlet.) These pamphlets have, as Mintz puts it, "a simple, seductive theme: The way for you to harmonize your life is to hormonize it." Take, for example, Mead-Johnson's pamphlet, "So Close to Nature," which claims: "Unlike others available for the same purpose, this preparation follows the principles and systems of Nature herself. Its actions closely resemble those of your natural menstrual patterns and works without upsetting the delicate balance of your normal body function."

Another major area of drug company cover-up was in investigating doctors' reports of complications arising during pill use. In the first place such reports were not solicited by the drug companies—nor the FDA. Furthermore, doctors were led to believe that when complications were reported, thorough follow-ups were undertaken. This was simply not the case. Often there was no investigation at all. In 1961 Dr. Kassouf notified G. D. Searle of a patient who had developed phlebitis while taking Enovid. He was simply told that there was "no evidence to implicate the pill." When follow-ups were undertaken, they were often very cursory. In 1966 Dr. Schuyler G. Kohl made a report to the FDA Committee on Obstetrics-Gynecology on the methods of drug company investigations. He reported that these investigations were often superficial and "reflected considerable concern over the company's image with the physician. He cannot be irritated—it's bad for our business relationships!"

While covering-up unfavorable reports about the pill, the drug companies promoted some myths of their own to the effect that the use of the pill was not only completely safe, but actually beneficial. Perhaps the most outrageous of these myths was contained in a book called Forever Feminine, published in January, 1966. It was written by Dr. Robert Wilson, a Brooklyn gynecologist. It advanced the theory that the pill could prevent menopause and make a woman youthful, sexy and able to enjoy sex, "regardless of age." Wilson described his "crash program" preparing a 72 year old woman for her marriage night. In 1964, the Wilson foundation had received \$17,000 from the Searle Foundation. In June, 1966, the National Cancer Cytology of New York announced that studies conducted by its medical director, Dr. J. Ernest Ayre, had shown that Enovid could not cause, and might even inhibit, cancer of the cervix. From 1963, G. D. Searle had given annual grants to Dr. Ayre.

In all this the AMA has been the handmaiden of the drug companies. Dr. Kassouf and others testified at the hearings that no doctor reading the AMA Journal could possibly be aware of much of the negative research on the pill. If published, he said, such research usually appeared in FDA reports or British medical journals. Approximately one half of the revenue of the AMA comes from drug company advertising in the AMA Journal. In 1967, Searle placed 77 pages of advertising in the Journal. It is no surprise, then, that the Journal should not be quick to publish reports of studies unfavorable to the pill and that it should, on the other hand, be quick to publish any study likely to please the manufacturers of oral contraceptives. In a letter to Dr. John Talbot, editor of the AMA Journal, Dr. Herbert Ratner criticized the "evolving

double standard in which what favors the pill, including preliminary results, gets ready publication, but what is adverse gets delayed or no publication at all."

In the September 30, 1968, issue of the Journal (six months after British studies had substantiated the clotting risk) a prominently displayed article came to the conclusion that there was no greater incidence of thrombophlebitis in pill-users than in non-pill-users. The study which this article drew upon in coming to this conclusion was at that time unpublished. Dr. Kassouf pointed out at the subcommittee hearings that this unpublished study itself states that it was not designed to provide a comparative incidence of thrombophlebitis in women using the pill and women using another method of birth control. The article in the *AMA Journal* was written by Dr. Victor Drill, director of biological research for G. D. Searle.

By contrast to British reporting, in the US even carefully substantiated scientific data was summarily squelched by the pill-pushers. One case of such managed news involved a study conducted by Drs. Myron Melamed and Hilliard Dubrow. In a 1968 presentation to the American Cancer Society, the doctors announced the following: A study of 35,000 women revealed a "small, but statistically significant difference" in the number of early cancerous lesions of the cervix in women using the pill and women using a diaphragm. The study was given to the *Journal of the AMA* for publication. It remained unpublished for several months because, according to Dr. Melamed, "We could not agree on the revisions—if that's what they want to call them." The *AMA* was encouraged to sit on the study by such leading experts as Planned Parenthood's Dr. Guttmacher. The study was finally published in the *British Medical Journal* in July, 1969. Questioned about the revisions, Dr. Talbot, editor of the *Journal*, said: "99 percent of the time, the corrections and criticisms that our consultants suggest must be incorporated into the article or we will not publish it."

The best allies of the drug companies in promoting the pill have been the "population experts." In planning for women's parenthood, doctors like Guttmacher, Rock and Hellman have ardently pushed the pill because of its virtual 100 percent efficacy in preventing conception. For years, they made light of the growing list of suspected complications and lent their support to scientifically unproven theories about the pill's benefits. Planned Parenthood's Guttmacher, for several years, promoted the "fertility rebound" theory—that a woman, who went off the pill would experience a period of increased fertility—until a report published in 1966 showed that the pill had caused sterility, temporary and permanent, in about 10 percent of the women studied. Dr. Rock insisted on a recent television interview, as he has done all along, that the pill is "completely safe."

The third and most avid population buff, Hellman, newly named HEW Asst. Deputy for Population Affairs, has always been nonchalant about possible complications of the pill. Asked about the possibility of cancer, he replied: "If there is going to be cancer, then it would take at least ten years to show up. . . . That would be 1972 at the earliest, probably five years later. And I think we'll be well away from the present pill by then." Furthermore, in "selling" the pill, these experts have consistently downgraded the reliability of other less effective (and less expensive) methods of contraception. Morton Mintz points out that Hellman always speaks of the diaphragm's 10 percent Mure rate without explaining that

There is **OTre to** (hi pM conspiracy than the pill. Drug companies **haw Ran** actively buying up patent rights on the Intrauterine **ft\*rite** (IUD). For example, Ortho Pharmaceutical **CoflaartMen tf** Raritan, Ntw Jersey, producers of the **aaaalat frTto>N\*»\*rn** aids for birth control, has purchased **pMfttkjjIRi 6\* \*e** Lipaas Loop IUD. According to **infauMV atHni**, it **taak** Ortho over six months to release Art I\*\*> **at** the **market** after they purchased the patent. ThH **OttH** caUt to no surprise. As one doctor close to **tkf afMPa\*/j** KJflrts, "Detail men [drug company promotion **mM**] A kt Ma (t push the loop, since for every \$6,000 **el m\$ aatfc**, tr\* t\* manufacturers stand to lose about **\$150,010 h>** pill salts."

Even the laws encourage physicians to prescribe the pill rather than the IUD. Because the IUD must be put in place by the doctor whereas the pills must be taken by the patient, the doctor is less liable if a woman becomes pregnant while taking the pill than if she conceives while using an IUD. The doctor can blame the pill pregnancy on the patient's negligence, while the IUD pregnancy cannot be passed off as a result of patient irresponsibility.

this accounts for failure to use it properly or at all.

Looking at the history of how recklessly the pill was marketed and promoted, the conclusion is inescapable that the pill has been, in the words of Dr. Hugh Davis, "a massive experiment with millions of healthy women." The avarice of the drug companies, the total ineptitude of the FDA and above all, the arrogance of the men doctors, population experts and manufacturers who promoted the pill are blatantly obvious.

By the time the Congressional hearings rolled around, many women had had enough: The time had come for women to put the pill and their right to live as liberated women—in fact, their right to live—in the right perspective. The 30 members of Washington Women's Liberation who interrupted the pill hearings several times raised issues of extreme importance which the subcommittee did not deal with at all. Chief among these is the relationship of the reckless marketing and promotion of the oral contraceptive to the secondary status of women in this society. "Would the pill have been so carefully marketed if it had been a male contraceptive?" the women asked. "Would it have been so recklessly promoted?" "Would side-effects have been so thoroughly squashed?"

An even more blatant issue which the women raised was the complete absence of women from the hearings. There were no women on the subcommittee; there were no women witnesses. Gaylord Nelson, chairman of the subcommittee, refused to respond to the women's request that they and other women be allowed to testify. Throughout the hearings Nelson said repeatedly that he would give "top priority" to any drug company that wished to testify. "Nothing," said one of the women, "makes the oppression of women more obvious than this hearing today." Perhaps the most important issue arising **tram fte** history of the pill and from the cover-up that has characterized it **fem** the start which the women raised is: What right have men (doctors, drug manufacturers, experts, government officials) to exercise any control or influence over the **met** personal functions of a woman's body?

—Elayne Archer

*EDITOR'S NOTE: ^Myne Archer is a member of the New York Women's Health Collective,*

# SHO Students Fight SAMA Drug Culture

LIKE ITS PARENT ORGANIZATION, the Student American Medical Association (SAMA) finds itself under attack these days from health professionals (or soon-to-be health professionals) who refuse to tolerate a profit-oriented medical system.

At its National Conference on Medical Education in Chicago last month, SAMA took a drubbing for inviting Dr. John Knowles to be the main speaker and for collaborating with the drug industry in its public relations programs. SAMA also faced a direct challenge to help fund and staff community-controlled free clinics run by such groups as the Black Panthers, Young Lords and Young Patriots.

SAMA, though now organizationally separate from the AMA, remains an important force for socializing medical students—laying out for them what "responsible political action" is. In the past, SAMA's position has been challenged by the Student Health Organization (SHO), a national organization of activist

*Who actually pays for the exhibits at this [conference]? Not the drug companies. They call the cost incurred "advertising"—aimed at tightening the connection between the drug companies and physicians. Advertising costs do not come out of profits—they come from expenses. What determines drug prices is the necessity for drug companies to make large profits beyond their expenses. Thus advertising costs, such as those for this "SAMA Resource Center" raise the price of drugs.*

*We believe that health care is a right to which all people are entitled; a corollary is that no one is entitled to make profits from providing health care and services. Drug companies feel differently. They have profit rates more than double the national corporate average.*

*Drug companies occasionally have the brava-do to claim that they act in the public interest. Is marketing drugs under brand names in the public interest? Drug companies use that device to charge many times the price for which drugs could be and often are (unknown to most consumers) available. Are drug companies' efforts to circumvent whatever regulation is imposed by the FDA in the public interest? Are experiments on human populations in under developed, non-white areas with drugs not yet deemed safe for "public" use in the US in the interest of the people on whom those experiments are performed? Is it in the interest of people that a few drug company executives, themselves from the upper economic class and answerable only to people of that class, control a major portion of American medical technology and dictate pharmacological research priorities?*

*Drug companies perceive what drugs the population needs through the lens of corporate profit. The people of the United States are unknowingly being charged for crass drug company propaganda! Instead of being party to this crime. SAMA should be fighting it!*

—Health Liberation Movement  
New York University Chapter

health science students, including nurses, social workers and medical students. Last month's conference was no exception.

SHO greeted the principal guest speaker with a leaflet, headed "Welcome to Chicago, Dr. Knowles. Good Germans Have Always Felt at Home Here," attacking Knowles' participation on the Viet Nam Medical Appraisal Team which found "no justification for the undue emphasis which [has] been placed on the civilian burns caused by napalm." The leaflet went on to point out that while it was not surprising that the AMA supports the war in Viet Nam, Dr. Knowles' support of the war is very revealing. This is not the first time Dr. Knowles, hailed by the medical profession and the mass media as a crusading liberal, has come under fire from medical students. At Columbia last fall, student members of a committee to select a new dean of the medical school rejected Knowles as "no liberal" [see BULLETIN, October 1969].

More directly, SHO challenged SAMA to "move to do more than just echo the updated but still empty rhetoric of the AMA" by supporting the concept of medical care for all through community-controlled free medical facilities with funds and volunteer manpower. "Programs," they said, "which send medical students into the inner city like missionaries going into the colonies will always be regarded with hatred and suspicion by the people these programs purport to serve. SAMA now has a chance to support community-controlled health care. SAMA must act now to support the movement for Free People's Health Care in the inner city."

What put SAMA most up-tight, however, was the mushrooming student discontent with the role of the drug industry in the health care system. Little wonder, since SAMA receives over \$300,000 a year from drug advertising in its journal *The New Physician*. Under some pressure from the activist students, SAMA asked the drug companies to change their usual student-conference pitch. Instead of bringing massive quantities of free samples for their conference displays, the drug companies were to provide "educational materials." So the detail men came armed not with the usual pills, but with over a quarter million dollars worth of the latest medical machinery—computers and so forth.

Confronted with students demanding that SAMA repudiate all associations with drug companies [see Box on this Page] and realizing that medical students are no longer as docile as they once were, SAMA officials feared violence. So they called a meeting to discuss the best way to provide police presence—in uniform or in plain clothes. Discussion at the meeting centered on how to protect the drug companies' quarter million dollars worth of machinery. When someone raised the possibility of personal injury resulting from police involvement, others shifted the discussion to the necessity to protect the drug companies' property. Plain-clothes police were finally decided on, and they were abundantly in evidence during the rest of the conference.

While it seems unlikely that student activism will significantly change the drug industry or the rest of the medical-industrial complex, the challenge to SAMA is clear: Join the struggle of community groups and health workers and consumers for responsive, responsible health care—or retire quietly into obsolescence.