Editorial: 
Back to School: Keep on Trackin'

In response to the Cambodian invasion last May, students forced many universities across America to shut down. All seven medical schools in New York City and many other nursing, social work, dental and medical schools around the country participated in the protest. Social and political events superceded the traditional educational process. Classes were cancelled, examinations postponed, while students turned from lectures in the aloof ivory towers of academia to the streets of real political experience. This transformation of the student role challenged the education system to its core. Now, in September 1970, as students return to their universities, the question is: Has anything changed?

In the health science schools there has been no change. The system of health science education still works the same way. Health science education has been described as a process of “de-socialization.” In the course of being selected for and trained at the various kinds of health science schools, students are systematically separated and isolated from other students, from their prospective patients and co-workers and from their own common sense and experience. Whole classes of students are channeled into separate levels within the health system: middle and upper class students into medical school (34 percent of all medical students’ families are in the top three percent of income earners in the country), working-class and lower-middle class students into nursing and social work schools; women into nursing, men into medicine. Within each professional school, students are taught an arbitrary set of professional “ethics” and roles, which set them apart from (and above) the layman. They rapidly learn less and less about how to cooperate with other professionals and more and more about how to work and be satisfied in an isolated professional function. The desocialization process is complete when doctors are separated from nurses, and nurses are divided from social workers, and when all three regard patients from the lofty and distant point of view of the “professional.”

Students are trained to be, above all else, “professional.” To be professional sounds benign enough, but in fact, professionalism serves as a defense of elitist decision making and of privilege. It did not always have such ugly connotations. As used by Flexner, in his attempt to reorganize medical schools in 1912, professionalism meant excellence through uniformity of teaching skills, experience and curriculum. However, today medical professionalism has grown increasingly to mean unaccountability, first to the consumers of service and second to other providers of service. The professional argues that his entire relationship with his client is technical; it is thus neither relevant nor possible for the lay client to criticize him or hold him responsible for his decisions. It is, of course, true that doctors and other medical professionals have unique and complex skills. Yet many of the decisions they make are non-technical and virtually all can be explained to people. Self-policing is the choice of the professional; it is not forced on him by the mysteries of his craft. Professionals also often regard themselves as more capable of making decisions than other people, even when their technical knowledge does not contribute to a particular decision. Their exclusive knowledge implies to them that they are more capable of understanding than other people are. Unaccountability leads to this extension of privilege. Specialization often accelerates this unaccountability. Some specialists try to develop a “knowledge niche” so esoteric that even other professionals will find it hard to hold them accountable.

At one time, professionalism also meant pride in craftsmanship, creativity and individuality. This definition has long succumbed to a defense of work often below the skills training of the professional. It was not too long ago that doctors struggled against relinquishing to nurses the right to give injections or to technicians the right to take X-rays. Nurses still argue that only a registered nurse is competent to distribute pills in a hospital, even though the nursing shortage has often compelled them to allow nurses’ aides to take over this function. Social workers are taught that there is a unique service function—being human—that can only be met by trained professionals, and they defend their prerogative to offer such human services. The impulse to craftsmanship has turned into the jealous coveting of professional tasks for prestigious and profitable ends, for the maintenance of the status quo within the hospital hierarchy.

Professionalism, in its current meaning, is not a guarantor of humane, quality services. Rather it is a code-word for a distinct political posture: professionalism means defense of the status quo. No change in work roles, hier-
The Enterprising
Medical Middle:
Student AMA

One of the first interactions that a future physician has with organized medicine occurs during his first few days of medical school. On registration day, some time while he is shoveling out money for tuition, books and school newspapers, he will more often than not also find a group called the Student American Medical Association (SAMA) waiting for some of his money. Often it is not clear to him that this group is not just another integral and compulsory part of the row of tables at which he must pay fees. Membership in SAMA, he is told, will enable him to purchase hospitalization and disability income insurance or life insurance, all at the lowest possible cost. He is told about SAMA’s inexpensive European charter flights, and about a long list of discounts on items as far-ranging as high-intensity desk lamps to automobiles at only $100 above dealer’s cost. There is participation in summer service projects in Appalachia and Illinois awaiting him.

And should he wish to involve himself in the decision-making processes of the organization, there are always committees to join, offices to run for, and conventions to attend. If he does join, he pays his membership fee just once and automatically becomes a member-in-good-standing for all the rest of his years in medical school. And if he becomes a member, he will probably do little more than receive his monthly publication, his occasional newsletter, and will never know much more about SAMA than he did on that first day of school.

There is a great deal which the student ought to know about the Student American Medical Association. It is, by its own declaration, “the world’s largest and richest student professional organization.” With chapters at 87 of the nation’s 95 medical schools, with a membership roll of 24,000 medical students (almost 65 percent of those in the country) and with a national office staff of 35 people, SAMA is indeed large. With a budget for the fiscal year 1970 of over 1.1 million dollars, it is indeed rich. And for the greater part of its life, it has also been moribund.

SAMA originated in 1950 as organized medicine’s answer to a progressive group called the Association of Interns and Medical Students (AIMS). At a time when only educa-
tors dealt with education, AIMS had suggested that it was also a legitimate concern of medical students. At a time when no one dealt with discriminatory admissions policies, AIMS had called for an end to the prejudice that closed the doors of medical schools to blacks and women. These actions were sufficient to incur the wrath of organized medicine. During the late '40s and early '50s, the AMA and a number of medical school deans, in the prevailing spirit of McCarthyism, combined to eliminate AIMS. The AIMS journal The Interne, bears silent witness to this assassination—large, handsome, thick with advertising in 1941; small, pathetically thin, devoid of any advertising one decade later.

Born unto the AMA, SAMA was reared to emulate and respect its parents. For the first 16 years of its life, SAMA was a model child. The young SAMA, described by the past editor of its journal as dominated by a staff of "non-medical executives essentially appointed by an insurance firm with economic interests in the organization," carried out programs and activities clearly envisioned by its constitution which states in part: "The objects of this Association shall be to . . . contribute to the education and welfare of medical students, interns, and residents; [and] to familiarize the students with the purposes and ideals of organized medicine . . ." The years 1950 to 1968 saw a great proliferation of narrow educational scientific programs such as symposia and forums and of service programs such as life and liability insurance, chapter of the year awards, and "Golden Apple" awards for outstanding faculty members. There were liaisons established with more than two dozen other professional groups, to familiarize the students with "the purposes and ideals of organized medicine." But it was not until 1967 that SAMA recognized that there was something else going on—a crisis in medical care. The 1967 SAMA convention's most dramatic act was to pass a resolution stating that local SAMA chapters should "be encouraged to start investigating the socio-economic problems of poor people . . ." In the same year SAMA realized there was a crisis in its own organization and it passed a resolution calling for the appointment of a student editor for its journal to replace the incumbent insurance executive. It was not until 1968 that the Student American Medical Association began to act on the health care crisis that had always been all around it.

What brought on this rather abrupt development of social concern was the influence of another organization, the Student Health Organization (SHO). Formed in the fall of 1965, SHO was not another medical students' guild; it included medical and nursing students and was open to all health science students. It was committed to action on a range of social issues, especially, at the outset, poverty and racism. SHO's summer service projects, bringing health care to ghetto and rural areas, attracted students in droves. Impressed by SHO's growth and vitality, SAMA began to pick up some of the new organization's ideas.

A "New SAMA" was born in the convention of 1968. Under a banner emblazoned with the words "Concern, Commitment, Action," newly elected president C. Clement Lucas spoke of the problems of ill health and medical education in the United States. SAMA began to make some long overdue changes. Its journal, The New Physician, took on a new look. It still kept much of its old scientific format including sections on X-ray consultation and the "EKG of the Month." But for the first time in its life, it also began to publish articles that would hold the interest of the students who knew there was more to medicine than technology. Articles began to appear on medical education and on community health.

With the election of Ed Martin as president at the 1969 convention, plans were set in motion for the creation of a summer service program placing medical students in Appalachia. Soon afterwards another project was created to place students in small community hospitals in Illinois. At SAMA's most recent convention, Charles Payton took over as president and most of the past leadership left the organization. There is new leadership for the "New SAMA." But is there a new direction? The "New SAMA," is two years old and its apparent change during that time raises for concerned students the question, "Just how far has SAMA really come?"

One ex-SAMA member has described its programs and resolutions as having about the same impact as Time magazine. Both present a great wealth of information on societal ills without the analysis necessary to show how all the problems are related. For example, SAMA has a program that is supposed to fight the health manpower shortage in Appalachia and in its resolutions has called for an end to discriminatory medical school admissions policies and for an end to the war in Vietnam. SAMA sees these symptoms, but has shown itself to be either blind or not really interested in the etiology — health as a low priority for a country that would rather spend its money on the Indochina war than on the lives of its citizens.

The SAMA project in Appalachia is a clear illustration of SAMA's symptomatic approach to treatment. During the summer of 1969, 95 medical students and 20 nursing students participated in the first Appalachian Student Health Project. The grant proposal for the project suggested it was a health manpower recruitment drive that would help correct the acute shortage of doctors and nurses in the area. The Appalachian Regional Commission, a billion dollar federal-state agency, desperate for ways to show how much it was doing for the Appalachian people's health, granted SAMA $247,000 for the project's first year. SAMA has made some clear political decisions on how to carry out the project. It placed most of the 115 students with private practitioners and worked closely with the Appalachian Regional Commission. During the program's orientation, SAMA carefully exposed the students only to those groups that in no way challenged the existing health care
delivery structure. SAMA did not place any program participants with doctors who fought black lung, or with community action or legal advocacy groups. Representatives of these groups had to come uninvited to the project’s orientation meeting in order to demand speaker time. And while they were arguing for the right to address the students, they incidentally discovered that the SAMA “interdisciplinary” approach meant giving separate but equal orientations to the medical and nursing students.

SAMA claims its Appalachian program is designed to “create among the student participants an awareness of the existing health programs, the problems of delivery of health care to and the general medical needs of a rural community” in order to “exert through the students an influence on medical and nursing school curricula in a way that would provide a larger, more significant output of personnel appropriately trained for the health needs of rural America.” Yet by placing the student participants only in working environments with established medical supervision, they will never develop an awareness of anything more than the community’s “general medical needs.” The student should have been allowed to speak and work with those who can suggest real answers for Appalachia. Only when he is allowed to see poor health as a reflection of poverty, and poverty a reflection of unemployment, and unemployment a reflection of a society that doesn’t care to employ West Virginian coal miners any longer when it is so much cheaper to automate, can he then see an answer to the ill health of Appalachia. If SAMA systematically isolates him from new options and non-traditional alliances to stimulate change, then he will, at worst, feel that by giving his summer he has done all that he can do for the people of Appalachia. And at best, he will return to the community some day and take over the well paying private practitioner role to which he has been exposed. In either of these cases he will do little to help stop the perpetuation of the malnutrition, environmental deterioration and industrial disease that await the unborn children of Appalachia.

After the summer in Appalachia had ended, Ed Martin, student program director and then SAMA president, told the Appalachian Regional Commission, “The program was sold to us on the theory that if we saw Appalachia we would come back and save it. That’s too simplistic. Appalachia is not a viable option for medical students wanting to get ahead.” The project had failed to accomplish at least one of its stated goals; only 18 medical students indicated any desire to return to Appalachia to live and practice. SAMA’s surprise at this failure is in itself surprising. If it was the Commission that had sold the program to SAMA, then one would expect that SAMA would not allow itself to be hustled into the same thing again. Yet, with essentially no changes from last year, the second Appalachian Student Health Project has just been completed this summer. Appalachia is still not a “viable option.” Students are still not returning. But the program continues.

Another SAMA program designed to deal with the unequal distribution of physicians in

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**SAMA CONTRAST:**

**STUDENT HEALTH ORGANIZATION**

In 1965, when most health science schools ignored the health problems of the poor and most career-minded health science students were indifferent to social and political issues, the only extant student health organization was the Student American Medical Association (SAMA). Activist students concerned with the crisis in the health system, as well as the society at large, saw the need for a new organization. SAMA was more concerned with insurance than with the social or medical needs of the poor. Its membership was limited to medical students: nursing, dental and social work students were excluded. Finally, SAMA’s link to the traditionally elitist and conservative medical establishment was so ingrained that contact with community and worker forces for change was non-existent. The Student Health Organization (SHO) was founded in reaction to the failure of the health science schools, the narrow elitism of most health science students, and the absence of a meaningful student organization in health.

SHO was held together initially by its program of summer service projects—patient advocacy programs serving migrant workers, survey of neighborhood health needs, screening programs for ghetto children, etc. The projects overcame the artificial separation of nursing, medical and social work students. They brought the students out of the abstractions of health science training schools into real human contact with the community. Increasingly, SHO placed students in contact with the community groups at the forefront of the movements for social change.

By 1968, there were SHO summer projects in nine cities. They involved over 600 students, at a cost of more than $1 million in federal poverty program funds. But many SHO students soon began to realize that adequate health care for the poor was not a problem of communication or social commitment alone: it was a problem of power. SHO projects seemed to do more to improve the public image of the health professionals and the medical schools than they did to change health services to the poor. Worse, student-initiated and student-conducted research surveys of community health needs and leadership armed the establishment health bureaucracies with information to deflect community demands rather than meet them.

SHO activists had discovered the two-class health system. Medical training, research and virtually the entire American health system is organized to meet the needs of middle and upper middle class consumers and providers. Millions of poorer Americans get inadequate.
the nation is called Medical Education Community Orientation (MECO). Funded by a three-year $125,000 grant from Sears Roebuck, MECO shares the Appalachian program's approach to education by exposing students to problems without encouraging them to go beyond superficial answers. Medical students in MECO are placed in community hospitals, which are hospitals not affiliated with a university, usually staffed by private practitioners, and without a regular program of medical student clerkships. The project is supposed to show that community hospitals are acceptable for student clerkships and, by implication, for internships. The idea is that the community hospitals, the majority of which are not now accredited for internship, will become accredited, and will attract interns who hopefully will stay in the community after their training. This theory has been warmly embraced even by the conservative president-elect of the AMA, Wesley Hall, who has stated that "Interns and residents should get out with the practicing physician. I think the preceptorship is extremely important. I would favor such a program, even for medical students... What MECO fails to take into account is that the number of internship positions in the nation's hospitals already far exceeds the number of available interns. Despite MECO, community hospitals in isolated rural areas will not compete well with the urban-centered hospital for interns.

SAMA's new stance of commitment is frequently contradicted by its actions, giving it the appearance of an organization working at fragmented care, which exploits them as teaching and research materials and maintains their dependence and their vulnerability to disease. The first place concerned health students chose to attack this system was the oppressive institutions which trained them to be part of the system. The SHO focus shifted from service programs to demands for minority admissions to medical schools (Philadelphia), stopping medical school expansion at the expense of neighborhood housing (Harvard), and mobilizing patients to demand adequate service at the teaching hospital (Columbia). At Northwestern Medical School last spring, 30 medical and nursing students occupied the Dean's office for 24 hours. They conducted a People's Health Free University to dramatize the school's racism in admissions, dual standard patient care in teaching hospitals, and oppression of students who attempt to respond to these political realities.

The change to direct political action within the health system rather than low-risk summer-time projects in the community has sapped what interest there was in the loose-knit national structure with which SHO began. Although an active communication network persists (the SHO Service Center, 1613 East 53rd Street, Chicago), no energy has been diverted to convening a national convention for cross purposes with itself. This conflict was made vividly clear when in 1968, the "New SAMA" was announced under the banner of "Concern, Commitment, Action." C. Clement Lucas saw no contradiction in also announcing discounts for SAMA members at Hilton and Ramada Inns and on Chrysler Corporation automobiles. The student who was to battle the ills of society was also going to first take advantage of his position in that society.

The same conflict reappeared one year later. During the 1969 SAMA convention, the delegates called for the creation of a standing committee on minority group admissions in order to deal with the "subtle conspiracy" of discriminatory admissions policies and prohibitive financial barriers that were denying these groups admission to medical school. By late that same year it was clear that the newly appointed committee had not shown any signs of life. Members of the all-black Student National Medical Association came to one of the committee meetings and helped to set up a five-man subcommittee that would assume the responsibility of setting into action the committee's supposed goals. The subcommittee offered a program that would have involved both researching the statistics on discriminatory admissions and contacting local community organizations in order to lay a political groundwork for direct community pressure on the medical schools. When the subcommittee requested the necessary funding for the program, money that had already been allocated to the committee as a whole, they were refused by SAMA's executive committee delegates who had called for an end to
the "subtle conspiracy," but who had unwittingly instead become part of it.

The SAMA journal, The New Physician, offers the most recent example of saying one thing and then doing the opposite. The journal advertises that it "...does not seek to be merely a repository of information, but a forum for the expression of ideas which are in the developmental stage." However, its actions do not support its advertisement. The June, 1970, copy carried an interview between Dr. Eugene Schoenfeld, "Dr. HIPpocrates," and an unidentified interviewer. The New Physician carefully does not credit the interview to Larry Brilliant, one of its contributing editors and now editor of The Body Politic, the much more radical journal of the Medical Committee for Human Rights. Nor did the editors bother to print Larry Brilliant's introduction to the interview, a piece which described the differences between political activism on the East and West coasts and was essential to the perspective of the interview. It seems as though The New Physician is a forum for the expression of only certain ideas.

Why is it that the Student American Medical Association treats symptoms instead of underlying causes and then works at cross purposes even to those misguided approaches? The reasons are many and complex and are best reflected in the organization's history and its leadership.

SAMA was born in an act of fratricide. By the very nature of its birth and expectations of its parents, it was a conservative organization. And constitutionally it was created as an exclusively medical student organization. These inertial forces make it hard for SAMA to change. Although it has attempted to declare its independence and rebel against its parents, like most adolescents it still needs its parents' love, approval, and money. C. Clement Lucas, before the AMA House of Delegates in September, 1968, addressed himsel to the health care problem saying that "...we worked behind the scenes to change and improve much of the organization. In the future, IFSMA is going to look to the U.S. for more leadership, especially in terms of the Americas, and the U.S. should be prepared to offer this. It is important to realize that the U.S. is the only really organizationally oriented country in IFMSA and can offer many suggestions for improvements in the functioning of IFMSA. The U.S. should become especially concerned with the problems of Latin and South America, and should in the coming year adopt Bolivia as a special project."

EXTENDING THE EMPIRE:
LIKE FATHER, LIKE SON

It was not surprising to the student activists who disrupted the 1969 AMA Convention when guest delegations were greeted from such countries as Taiwan, South Korea, South Vietnam and "Cuba-in-exile." The reactionary politics of the AMA seemed consistent with honoring these right-wing American client-states. Recent SAMA resolutions opposing the war in Vietnam leave the impression that SAMA has repudiated the foreign policy of its parent. However, the following statement made by C. Clement Lucas (past SAMA president), to the SAMA executive council concerning his visit to the assembly of the International Federation of Medical Student Associations (IFMSA) in Helsinki raises doubts about the shift toward independence by the new SAMA leadership:

"It can be seen that even though the U.S. didn't assume a vocal role in the assembly, we worked behind the scenes to change and improve much of the organization. In the future, IFMSA is going to look to the U.S. for more leadership, especially in terms of the Americas, and the U.S. should be prepared to offer this. It is important to realize that the U.S. is the only really organizationally oriented country in IFMSA and can offer many suggestions for improvements in the functioning of IFMSA. The U.S. should become especially concerned with the problems of Latin and South America, and should in the coming year adopt Bolivia as a special project."
Nursing Education: Teach the Woman to Know her Place

The young woman just entering nursing school faces her education with great apprehension. Her most pressing questions are: Will I be able to learn how to give the best possible care for the sick? Will I be able to learn how to work most effectively with the doctor, my fellow nurses and the non-professional workers? Will I be able to learn how to be “a good nurse” and help change nursing to be better? After only a few short months in nursing school, however, the student nurse no longer sees these questions as relevant. Instead, the most important questions for her have become: Will I do everything exactly the “right” way, i.e., the way the supervisor wants them done? If I make any changes will I be doing something so hideously wrong that the patient will die? Will I express the right attitude toward my work so that I can stay in school?

The student nurse and the young nursing graduate have been molded through their education to see themselves not as important workers or decision makers in the health world but as minor cogs in the health system wheel. They can only do what they are told and cannot make decisions because that is not their assigned task. Though the elite in nursing like to think that nurses have major responsibility for patient care, this is largely illusion. For the most important message communicated to potential nurses and nursing students is “don’t rock the boat.” Even in the most limited sense, individual imagination and initiative in providing nursing care is out of line. And any nurse who challenges the basic structures and relationships in the health system is considered a heretic by the women who dominate nursing leadership: the educators, the supervisors and the administrators.

The roots of this conformity, this passivity, this fear of change stretch back as far as the recruiting programs for potential nurses and continue through the whole educational process. This article will try to trace that development.

The recruiting process must steer women into one of three kinds of registered nursing program: the baccalaureate (B.A.) or four-year college degree programs; the Associate
are told that they will have two years of diploma schools. The prospective students seem to feel forced to use any method they such dead end education, and some schools part because of the growing unpopularity of hospital schools are closing down rapidly, in national levels without starting all over again. ing it impossible to go on to higher educa­
cation. This is sometimes true; more schools are linking up with colleges so that their stu­
dents can be appropriately molded in per­
sonality as well as properly trained technically.
Perhaps the most blatant examples of recruiting for self-serving interests originate from hospitals and hospital schools. They try to draw women into hospital-based "diploma schools." One advantage of this to the hos­
pitals is that students trained in hospital schools are directly "educated" to serve the hospital's needs, which, however, frequently conflict with the individual's expectations that nursing will be a way of helping people. Hos­
pital nursing schools are also a convenient mechanism for insuring an adequate supply of nurses for hospitals. The student nurses themselves provide nursing care for patients during their education. And they often remain at the hospital at which they were trained after graduation.

At hospital schools, a prospective student is frequently told that she will be taking some courses for which she will receive college credit. This is sometimes true; more schools are linking up with colleges so that their students can go on for their bachelor's degree. But in most cases this is a lie; the courses may be given by college teachers but the students receive no college credit for the course, making it impossible to go on to higher educational levels without starting all over again. Hospital schools are closing down rapidly, in part because of the growing unpopularity of such dead end education, and some schools seem to feel forced to use any method they can to attract students.

The recruiting for A.D. programs is very similar to the misleading recruiting used for diploma schools. The prospective students are told that they will have two years of college work which they can then use to transfer to a regular collegiate school for nursing. However, this is often not true. For example, the New York University catalog states: "Courses in the baccalaureate degree nursing major are at the upper division level and have substantial prerequisites in the arts and sciences for admission to them. Courses in nursing taken in associate degree and hospital schools are not equivalent in level or complexity of these requirements and may not be accepted for advanced standing credit."

Another mechanism for selecting women for the various types of nursing programs is the high school guidance counselor. One nurse who was interviewed related the fact that her guidance counselor told her that she was too smart to be a nurse. This is a typical statement which is often repeated to white-middle class students. If such a student does persist in choosing nursing, invariably she will be shepherded into a collegiate program. Black or poor white students by contrast are typically guided into diploma schools or A.D. programs, even though there has been a great deal of money available for scholarships to collegiate nursing programs. Often guidance counselors brief visiting nurses about the programs they should stress when talking to a particular group of prospective students. If the counselor determines that the group of students is not "college material," the nurse is told to gear her talk to Associate Degree and practical nursing (P.N.) programs. Typically, when there are many black students in the group, the A.D. and P.N. programs are stressed.

The conception that nursing is a woman's task has led to sexist and sex-biased recruiting for the field. Guidance counselors never suggest a nursing career for men. Any boy who might consider nursing is frequently frightened away by the oft-made association of homosexuality with the male nurse. One way in which men do get into nursing is via the army medical corps. Some black men enter nursing, especially practical nursing, because it is a relatively secure, fairly high paying job for blacks who are excluded from many other skilled jobs. However, few men consider nursing itself as a career; rather it is often seen as a stepping stone to some other job, such as hospital administration. Nursing educators contribute to the perpetuation of the sex-biased image of nursing. As one nurse so coyly stated, "Many students lighted the lamp in adolescence when the feminine consciousness began to awaken."

The Armed Forces, in their nurse recruiting, also take advantage of the fact that nursing is mainly a women's profession. They utilize overtly sexist propaganda to entice women into the service. Their pamphlets allude to the availability of marriageable men and illustrate their point with alluring pictures of nattily uniformed officers embracing attractive blue-eyed, blond nurses. These pamphlets also describe the excitement and glamour that await the prospective military nurse.
To make their programs even more attractive, the various programs, whether they are sponsored by the Army, Navy or Air Force, offer to pay for two years of schooling in return for two years of service.

Traditionally, the registered nurse has been white and the practical nurse has been black. But now, nursing manpower needs require recruiting more black women for registered nursing to staff inner city hospitals. Since this recruiting campaign has been waged by the white, professionally oriented nursing leadership, there are often racist notions behind their recruiting drives. Major campaigns have been started in urban high schools to get black and brown women to train in A.D. programs. Besides school visits by nurse recruiters who explain the opportunities for black women in nursing, pamphlets and brochures have been prepared to circulate in inner city high schools.

One such pamphlet, printed by Ex-Lax Corporation and prepared with the cooperation of the American Nurses Association, features many pictures of black nurses and nursing students in the hospital setting. On the surface the pamphlet seems to be an honest attempt to recruit black women into nursing. But the thematic undercurrent of the pamphlet is that nursing is a good way to make it in the white world and to fit into the value system of white middle class America. To appeal to the image of the black women as perceived by recruiters, the text of the pamphlet is supposedly hip: "Think about being a nurse. It's really where the supercool action is. You'll wear a smashy dress." The conclusion is clear: "When you become an 'R.N.'—you're somebody." Become a nurse and get out of the rut of being black.

But nursing recruiting serves more functions than just producing enough bodies for the various programs. The chosen women must also have a personality that can be molded into the traditional role of a nurse: self-effacing, subservient, and willing to take orders without asking questions. In part, this personality screening is the recruiter's job. But self-selection also plays a role. Only women who identify with the mass image of nursing portrayed by the media are likely to want to become nurses. The prevalent image of the nurse is gleaned from books, movies, television programs that depict her in the most traditional roles. For the pre-teen there are heroines like Cherry Ames, Student Nurse, who is depicted as the self-sacrificing, hard-working, dedicated angel. For the older girl, there are the thousands of pocket books about seductive nurses and their sexual exploits. On TV, the doctor stories show the nurse as a beautiful, dedicated, handmaiden to the masterful (and sexy) doctor. The "good" nurse is the silent helper who gets her reward by marrying the doctor.

Often the expectations of nurses-in-training still do not jibe with the needs of the medical profession. Surveys show that many women enter nursing because they want to help people. Students think of nursing in terms of dedicated service, care and concern and improving health care. But what the incoming nursing student thinks is of little importance. What matters is whether she can be fitted into the mold prepared by the decision makers in nursing. For them the important values are order and routine, meticulousness, hard work, emotional control and restraint.

The education of the student nurse, whether it be in a diploma, associate degree, or baccalaureate nursing program, is essentially a "desocialization" process. Throughout her nursing education, the student is exposed to a multiplicity of experiences which evoke fear, guilt, and humiliation and which ultimately undermine her personal value system, alienate her from her common sense, and stifle her desire to create and experiment. These experiences in effect program the student who will later, as a graduate nurse, be expected to fit smoothly into the existing health care system without rocking the boat.

One of the first things the nursing student learns is that there is a "right way" of doing things. There is a "right way" to do trivial things such as making a bed, and a "right way" to do critical things such as treating a patient who is hemorrhaging. "If you make a mistake," the student is told, "the patient might die." When evaluating the student's performance, the nursing instructor fails to consider the relative importance of various tasks. The student is taught to think that deviating from what has been taught, no matter how unimportant the task, will have serious consequences. One graduate nurse, considering her experiences during her freshman year, recalled: "My instructor came into the room to inspect a bed I had made. She was angry and disgusted because the sheet was wrinkled. I felt like I had done something really horrible . . . like I had done something that might really hurt the patient." Another student tells of being severely disciplined for failing to wake a patient in order to change his bed linen. Her explanation that the patient had not slept for several nights and that he needed undisturbed sleep more than clean linen was judged irrelevant.

It is certainly true that mistakes could cause injury or death to a patient; there are many procedures for which there is indeed a "right way." Many other tasks performed by nurses, however, could be improved with imagination, innovation, and flexibility. But the use of personal judgement is discouraged in nursing school because the function of nursing education is to produce a nurse with predictable, unimaginative behavior that can always be molded to fit the needs of the medical profession.

The "right way" is a theme which permeates all of the student's classroom and clinical experiences. Its roots, of course, lie in the many medical tasks for which the "right way" may indeed be a life-or-death matter. But the use of this theme to stifle individuality in less critical tasks originates, in part, in the nursing educator's desire to standardize the kind,
quality, and level of patient care the nurse will later provide. The "right way" is also rooted in the educator's fear that the young student is lacking in common sense. Often the educator assumes that the student has had little life experience and few personal values, or perhaps the wrong kinds of experience and values. Consequently, the educators see their task as an enormous one. They must first inculcate values and then show the student how to perceive, interpret, and respond to each and every situation, keeping these values in mind.

Most students diligently attempt to follow the instructors' orders and values, however absurd. It may not ensure or even be relevant to patient care, but it certainly is necessary to her own survival as a student. In time, she internalizes the rigidity she has been taught.

Having been taught that the patient is a person and that every person has dignity and worth, the nursing student proceeds to learn how to do things to him. She is drilled in the arts of making his bed, taking his temperature, bathing and bandaging him. In laboratory settings which are simulated hospital rooms, the student performs these functions over and over again until she "gets them right." Only then does she move on to the "real patient," who now, for the student, begins to take on the appearance of the dummy she practiced on in the nursing laboratory. One student explained: "I had heard so much about the 'patient'—what he likes, what he needs, how he feels—that when I was confronted with him, somehow he didn't seem quite real."

The effect of this kind of education is destructive to both student and patient. A recent study of nursing students' experiences in a nursing program reveals that "students reported having symptoms of anxiety, nervousness, depression and restlessness, very often." Another study reveals that "students do not appear to value independence of action to a great extent." A third study demonstrated that in the course of their education, students, who originally saw themselves as providers of care, came to envision their roles as those of supervisor, administrator, or nursing educator.

From these findings one might infer that for survival, one of the student's primary needs is that of keeping safe, i.e., reducing her own anxiety and "making it" through the educational system. She can accomplish this through strict adherence to the rules, engaging in ritualistic behavior, and by avoiding ambiguous situations which necessitate creative thinking. When the young nurse leaves school she will find that she must behave in exactly the same way to "make it" in the health system.

One way in which the student can combat her feelings of powerlessness is by allying herself with her oppressors: the nursing educator and the physician. One study revealed that bonds between nurses and doctors were stronger than patient-nurse bonds. Feelings of powerlessness are also reduced by exerting power over ancillary staffs—practical nurses, nurses aides, and the like. One student recalls being told by her instructor: "The workers under you are the bottom of the barrel and it's your duty to teach them."

The attitudes and work habits the student learns in school, the allegiance to the doctors and the supervisors, the exploitation of non-professional personnel are all the things necessary to maintain the health system as it now exists. Baccalaureate nurses see themselves at the top of the heap in relation to other nurses. A.D. and Diploma nurses in turn see themselves as separate from and more important than the non-professional staff but still subservient to nursing leaders.

The process of nursing education fails to prepare young men and women to challenge what they will later experience when they enter the health care system as full-time workers. They learn that it is safer to perpetuate the existing health care system than to challenge it. For the student, any intention of being the patient's advocate is lost somewhere during the beginning of his or her education. Having had little opportunity to explore her own values and ideas or the discrepancies between the ideals she had about nursing

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(*90% of all Puerto Ricans go to medical school in Puerto Rico)

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Social Workers: Keeping the Pieces Together

An estimated 4,500 students begin training programs for professional social work this fall. Fifteen percent of them, one out of six, will be employed in a health setting. Three years ago, in 1967, the Public Health Service estimated that of 130,000 social welfare workers in the country, 20,000 were in "health and related" programs. That number of social welfare workers (which includes those without credentials as well as those professionally trained) is a tiny proportion of the 3.5 million-plus health workers, and is only about one percent of even the 1.5 million technical and professional workers in the health system. As a voice for reform among health workers they are numerically insignificant. And in terms of "helping people," social workers probably have no greater facility or opportunity for patient or community advocacy than other health workers. But the public exposure of what they have to live with each day is a potentially special contribution of social work personnel.

The social work function as idealized by social work professionals—and as taught to students in social work schools—sets a high rhetorical standard for human concern. Client advocacy, whereby the social worker fights for the rights of the patient, is upheld, in the words of one social worker, as "our challenge, our commitment, our practice." Community involvement is stressed: the responsibility to develop a partnership between the hospital and the community it serves. The social worker is envisioned as a full member of the interdisciplinary health care team in the hospital, actively educating others to the human needs of the patient and sensitizing them to the social and environmental basis of disease. Supposedly bringing professional skills to bear, the social worker counsels individuals and families on the traumatic effects of illness or on special needs resulting from illness, such as child care, vocational retraining, homemaker assistance, after-care facilities, etc. More broadly—and vaguely—the social worker assumes responsibility for confronting the whole gamut of basic needs which affect the health of the under-privileged: poverty, poor housing, unemployment. Having laid claim to so much turf, understandably, even the most enthusiastic and progressive social work administrators add a caution about the limits to "what the hospital can do."

From the hospital administrator's perspective the social workers' role is to give specialized attention to the human problems attending patient care in order to free nursing personnel for strictly medical duties. The historical reality seems to be that social work became an established component of modern hospital administration as an expression not of the vision of professional social workers but rather as part of the shifts by the medical authorities toward specialization and increasing professionalization of health care functions. Their goal has been to best utilize precious "medical" manpower for "medical" tasks.

The irony and contradiction is that those gestures toward science and efficiency take place within a structure that sets other priorities ahead of health care—training doctors for private practice, maintaining the primacy of the class system and the right of MDs and drug companies, etc. to sell health care to those who can afford it, treating sickness instead of providing for health (by preventive care). The basic problem in making health care human is not the way in which the health
service manpower is utilized but the priorities it is committed to serve. The effect of artificially creating a specialized field—"social work"—concerning patients' "human" or "social" problems in an institution which is part of the social arrangement that creates those problems is that social work units and personnel become a kind of dumping place, a refuse disposal in the hospital system. The human needs which cannot be disregarded, suppressed, channeled and controlled by the routine procedure for compartmentalizing people's health needs are turned over to the social work staff.

The compartmentalization which creates the social work role is described rhetorically by the social work profession in terms of applied humanism and by the hospital: medical administrators in terms of efficiency. But it is the priorities and structure of the health care system that create the reality of the social service work-day. The social worker spends most work hours in dreary paper work and bureaucratic routines concerned with admitting and discharge, and especially with the financing mechanisms for medically indigent patients. The lack of continuity, the inconsistencies, the obscurity of the procedures for Medicaid and Medicare and the rigidity of the hospital bureaucracy set forth a day's tasks.

The only way most social workers see to escape this dreary routine is by attempting to help individual patients. But individual client advocacy is an all but hopeless task. A social worker who works in one ghetto hospital, reports that her "humanizing" function often consists of such tasks as finding clothing for people who need something to wear out of the hospital because the only clothing they owned had to ripped off in emergency admission.

Other attempts at helping individuals are equally pathetic. One social worker intervened in the case of a patient who was being treated for a leg fracture. In talking to the man, the social worker learned that the fall had been caused by one of the man's frequent dizzy spells. She brought this to the doctor's attention and exacted from him the promise to refer the patient to the medical service where tests would be done for suspected epilepsy. But the patient was discharged over the weekend—pointing up the doctor's inattention to the man's over-all medical needs in the face of the higher priority of freeing a bed. The best the social worker could do was to write to the patient and tell him to go to the out-patient clinic for tests and treatment of his dizziness.

Another worker had to intervene in a case of misdiagnosis caused by a doctor's ignorance of community life-styles. The patient was referred to the psychiatric ward from surgery because he was hostile and agitated. There the psychiatrist diagnosed the patient as a homosexual on the basis of the patient's clothes (he wore red silk pajamas and a scarf around his hair) but as the social worker pointed out, the patient's clothing and the stream of women visitors indicated that he had been a pimp or hustler.

Yet another social worker described one of her most important tasks as the education of doctors to enlighten them about the conditions of extended care facilities. She took residents on field trips to the state hospital's geriatric wards to which many patients were discharged. The medical supervision tried to stop the trips because they objected to "upsetting" young doctors by exposing them to the horrible conditions to which they would be sending patients. But in fact, patients who can't go home are sent to "dumping grounds," whether the doctor knows their horrors or not. As one social worker delicately put it . . . "When one has to send a patient to an unpleasant disposition, one has to put on blinders." In the end, all the individual attempts of social workers to help their clients are at best, drops in the bucket. The health care and other social services required by these patients are simply not available to them.

In the growing upheaval over accountability of service deliverers to the community they are supposed to be serving, the social work hospital personnel are one potentially catalytic minority of the work force. The decision to siphon off "people problems" to a special work group in the hospital creates a special turf, an artificial but usable moral respectability for speaking out on the human effects of the present hospital system. Social workers have historically exploited that peculiar morality to justify their "professionalism." They have suggested that it is their special mission to see, to understand, to be skilled in treating the "human" aspects of health care. Their logic leads from the right demand for more humanism and concern to the wrong demand for more status, authority, and funds for social work. It is the structure of the hospital system itself, however, that dehumanizes—that requires dehumanization, that reduces the need for comprehensive care for the health of any individual human to a set of categorized sicknesses. What can change that is not more social work. What can change that is basic reforms in health system.—Michael Smukler and Connie Epstein

Bronx Community Wants Control

The Bronx has the City's largest, most highly centralized medical empire, the Einstein-Montefiore empire. The Bronx also has the most inequitable distribution of health resources of any region of the city. For the white, middle-class, and doctor-rich north and western sections of the Bronx, there are the empire's prestigious core institutions—Montefiore Hospital and Einstein's college hospital, plus a number of smaller voluntaries. For the densely populated, disease-ridden black and
Puerto Rican slum of the southeast Bronx, there is essentially only one health facility—Lincoln Hospital. If construction of a new municipal hospital on the grounds of Montefiore is completed, the disparity will increase, and the strain on already-overloaded Lincoln Hospital will reach the breaking point.

Lincoln Hospital is owned by the City, staffed with professionals by Einstein, and neglected by both. Twenty-five years ago the City initiated plans to replace the deteriorated, century-old Lincoln plant with a new building, but ground for the new Lincoln has still not been broken by mid-1970. This year the City hit Lincoln with a three percent decrease in its operating budget, threatening cutbacks in vital outpatient services. To Einstein, Lincoln's affiliated institution, Lincoln serves as an outpost for the training of young doctors and medical students. Einstein has taken little or no initiative to develop community health programs, to provide for continuity of care in the clinics, or to make the services more dignified and acceptable to the community. When confronted with angry Lincoln workers and community residents a few weeks ago, an Einstein dean asked, in apparently genuine ignorance: "What do you expect from us?" Someone answered, "We want you to make Lincoln as good a hospital as your college hospital." The dean had no reply. To Einstein and to the City, Lincoln has always been and will remain, a second-class institution.

This summer's community and worker drive for control of Lincoln Hospital stems out of months of community and worker frustration with the hospital and its current leadership. The first major eruption was in April, 1969, when workers in Lincoln's community mental health center, dissatisfied with Einstein's patient care and personnel policies, seized the center and operated it for a couple of weeks under community/worker control. [See April, 1969, BULLETIN.] A combination of police force and manipulation by Einstein ended the mental health rebellion, and, for more than a year, demoralized the dissident workers. Then in February, 1970, there was a brief flurry when Lincoln's usually inactive official community advisory board challenged the City Hospital Department's selection of a new administrator for the hospital. Nervous about a repeat of last year's community/worker uprising, the City acceded to the board and Lincoln got its first Puerto Rican administrator. But by June it was clear that nothing really had changed: To its workers and patients, Lincoln was still the community "butcher shop."

Community and worker impatience grew throughout the spring. By June there were three local organizations ready to make an all-out effort to improve Lincoln: The Young Lords Party, the Health Revolutionary Unity Movement (HRUM), and Think-Lincoln. The south Bronx Young Lords, a group of revolutionary young Puerto Ricans, is a chapter of the Young Lords Party in East Harlem, which has placed major emphasis on health, hospital and sanitation issues. HRUM, a citywide organization of black and Puerto Rican hospital workers, came together in Lincoln, as in several other City hospitals, around a ten-point program for improved community health services under community/worker control. Think-Lincoln is a community and worker organization dedicated solely to doing something about Lincoln Hospital.

The combination of these three groups, plus continued deterioration of conditions at Lincoln, produced a chain of events which has rapidly escalated to the brink of an actual community/worker takeover of the hospital:

June 17. The seven demands: Think-Lincoln presented Lincoln's new administrator, Dr. Antero LaCot, with a list of seven demands: (1) No cutbacks in services or jobs (as a result of budget cutbacks). (2) Immediate construction of the new Lincoln hospital. (3) Lincoln-operated door-to-door preventive health services. (4) A 24-hour a day grievance table for Lincoln patients and workers. (5) A minimum wage of $140/week for all Lincoln employees. (The current minimum is $118/week. At its July, 1970, contract negotiations, Local 1199, one of the unions representing Lincoln workers, had initially demanded a $140/week minimum. The union settled for an increase to $130, effective July, 1971.) (6) A day-care center, funded by the hospital, for children of Lincoln patients and workers. (7) Total community/worker control of all health services at Lincoln Hospital.

Think-Lincoln wanted an immediate decision on the grievance table; LaCot reportedly said he'd think about it. The next day, Think-Lincoln went ahead and set up a table in the emergency room waiting area, meeting unexpectedly little resistance from the administration. The table quickly had more business than it could handle—patients complaining about long waiting times or brusque treatment and workers complaining about working conditions and unfair treatment, etc. Though they lack any formal authority to redress the grievances which are brought to the table, Think-Lincoln has still managed to right a few wrongs. When patients complained about long waits in the screening clinic, Think-Lincoln chastised the clinic doctors, who had been arriving late and leaving early. The doctors, who had never before been challenged on their work habits before, are now reportedly working full time.

June 28. March through the neighborhood: Young Lords and Think-Lincoln members marched through the South Bronx, passing out leaflets announcing a rally on health issues to be held the next day. As they marched, dozens of people in the streets joined them. Alarmed at the growing crowd, a large group of police attacked. Ten marchers were arrested; all were beaten on the way to the precinct house; and, according to medical witnesses, three were seriously beaten and tortured inside the precinct house.

June 29. Rally in St. Mary's Park: Undeterred by the previous day's police violence,
Think-Lincoln held the scheduled rally in a local park. Free on-the-spot medical care and TB screening offered at the rally underlined the deficiencies of Lincoln.

July 13. Garbage offensive: Think-Lincoln and HRUM collected trash littering the floors of the clinics and halls, and dumped it in a pile outside the administration offices. Since this action, trash collection in the hospital has improved remarkably.

July 14. Takeover of the Nurses’ Residence: There had still been no response from the administration on the seven demands, and complaints were piling up at the grievance table. At five in the morning of the fourteenth, members of Think-Lincoln, HRUM, and the Young Lords occupied a building adjacent to the hospital which houses a nurses’ residence, personnel offices and some mental health services. In the course of the day, members of the house staff, workers and community people joined the original occupiers, bringing the occupying force to nearly 100 people. Patient care in the hospital was in no way disrupted, but the administration was fearful of the impact of the takeover on the rest of the workers. LaCot took a carrot-and-stick approach to the occupier: On the one hand he conceded to two demands—that there would be no cutbacks in services, and that the occupiers could set up a screening clinic in the nurses’ residence. On the other hand, he called in a sizeable police force to surround the hospital buildings. In the late afternoon, he announced to a meeting of the house staff that police intervention had become necessary to end the occupation. Half the assembled doctors walked out of the meeting and joined the occupiers—both to provide first aid in case of violence, and to take a stand with the community and worker forces. The occupiers decided, however, not to wait for a police attack, and at about five in the afternoon, quietly left the nurses’ residence.

The brief takeover fell far short of winning the seven demands, but it brought them home with dramatic force to the entire Lincoln community. Everyone, from department heads to janitors, was discussing the demands, especially the one for community worker control, and workers flocked to Think-Lincoln meetings. For many patients and workers, the overriding effect of the takeover was a new sense of what could be done to improve the hospital, given the will to do it. In the wake of the takeover, house staff in pediatrics and in the screening clinic swept aside bureaucratic restrictions which interfered with care but had never before been questioned. Patients waiting for prescriptions at the pharmacy, led by a Young Lord, demanded that the pharmacists open up an additional window for service. (There were enough pharmacists to man the additional window; they had just never thought to open it.) As one member of the house staff put it, “We felt liberated. We were doing things we wouldn’t have thought of, or dared to do, before.”

July 19. The Death of Carmen Rodriguez: Up until this point Think-Lincoln, HRUM and the Young Lords had held the initiative and set the pace of the struggle. The next event was planned by no one. Mrs. Carmen Rodriguez, a mother of two, died suddenly in the course of a therapeutic abortion in the obstetrics ward. A psychiatric resident who had known Mrs. Rodriguez in a drug treatment program, decided to take a look at her medical chart. What he found was clearcut evidence of malpractice: The handling of the abortion had not taken into account the patient’s history of rheumatic heart disease. According to doctors who later studied the chart, medication given during the abortion had apparently precipitated heart failure. Rather than simply having it out with the obstetrics staff, the psychiatric resident took the highly “unprofessional” step of reporting the case, in full detail, to Think-Lincoln.

Think-Lincoln members and other community residents had repeatedly charged that Lincoln was unsafe and a “butcher house,” but they were deeply shocked to be confronted first-hand, with a well-documented case of an entirely unnecessary death. On July 20, they presented Lincoln administration with four new demands: (1) that Lincoln Hospital pay damages to the Rodriguez family; (2) that the Lincoln abortion clinic be named the Carmen Rodriguez Clinic. (The abortion clinic had been set up only weeks before, with the repeal of the State abortion laws:); (3) that a watch-dog committee of community residents and workers be set up to monitor the Lincoln abortion program; (4) that Dr. J. J. Smith, the head of the obstetrics department, resign immediately. The Think-Lincoln leaflet announcing the demands signed off with the statement: “A human life is worth more than the riches of the wealthiest man in the world.”

The takeover of the nurses’ residence had given people a sense of what positive things could be accomplished if patients and workers controlled the hospital. But the death of Carmen Rodriguez showed that community worker control was not just a matter of making modest improvements; it was a matter of immediate, life-and-death urgency. Not only was the existing leadership of the hospital (chief doctors and administrators) unable or unwilling to make improvements; it could not even be trusted to carry on basic medical services. “Community-worker control” was no longer just a slogan. To the staff of Lincoln Hospital, it had become a very realistic and imminent alternative.

The community-worker control demand is ultimately a challenge to Einstein medical college and to the New York City Health and Hospitals Corporation (which took over the municipal hospitals from the Department of Hospitals on July 1, 1970). But both parties have so far tried to keep a safe distance from Lincoln, leaving their on-the-scene representatives to cope with the insurgency on a day-to-day basis. The Corporation’s representative, Dr. LaCot, has, on the whole, been surprisingly flexible, even cooptative. Administrators in other municipal hospitals would
have called in the police over even as minimal a "provocation" as the grievance table; LaCot held off through most of the takeover of the nurses' residence. During the takeover, LaCot told the press that he felt the seven demands were "for the most part, reasonable," and later, when a dozen doctors threatened to resign because of community "harassment," he told the New York Times, "It is the opinion of this administration that there has not been, to the present, any incident of intimidation or of harassment which may be associated with any community group involved at Lincoln Hospital." On the other hand, Dr. LaCot has by no means become an advocate of the seven (and then the four) demands within the Corporation—he has simply tried to keep the lid on things at Lincoln.

According to Think-Lincoln members, the administrator's so-far mild response probably reflects his own powerlessness vis-a-vis the downtown Corporation, Einstein, and the community, rather than any deep-seated sympathy for the insurgents and their demands. Just the existence of the insurgency has increased LaCot's bargaining position, for funds and power, with the Corporation and Einstein. Perhaps more important, the administration understands that any hasty acts of repression could accelerate the struggle and precipitate a large-scale repetition of last year's takeover of the mental health services.

The response of the professional staff may turn out to be far more important to the outcome of the struggle than that of the administration. What is being challenged is not simply administrative control, but professional power as well—especially in the demands for the resignation of the chief of obstetrics and for a community-worker watchdog committee to monitor the abortion program. So far the chiefs of service (who are also Einstein faculty members) have tried to remain aloof from the struggle, or have responded defensively, in some cases even hinting at resignation. No chief of service has taken a stand in support of the Think-Lincoln demands.

Among the house staff, however, there is a deepening polarization over the issues raised by Think-Lincoln. As workers, the interns and residents have reasons to identify with the community/worker struggle: Like many other hospital workers they are severely overworked, frustrated by shortages of equipment and supporting personnel (nurses, technicians, etc.), and denied a significant voice in hospital decision-making. But many of the house staff at Lincoln, like young professionals in other settings, find it difficult to think of themselves as workers. Other hospital workers are black and Puerto Rican, from lower class backgrounds; the house staff, whether American or foreign-trained, is predominately upper-middle-class. Other hospital workers are stuck in dead-end jobs; the house staff, by definition, are in training and on their way up (often to lucrative private practices in the suburbs). Above all, as young doctors, the house staff have completed years of medical education which is consciously designed to instill a sense of professional elitism, and separate them from other health workers.

At Lincoln, some degree of conflict over the role and responsibilities of the house staff had existed well before the current struggle began. In 1969, a small group of house staff in pediatrics, frustrated by the episodic, crisis-oriented medicine they were forced to practice, decided to remodel the pediatrics service as a comprehensive, community-oriented health program. (The Lincoln pediatrics program will be discussed in detail in a future BULLETIN.) With the approval of the chief of pediatrics, they set about making contact with health-oriented community groups, meeting with other workers in the pediatrics department, and recruiting, as interns for 1970, a group of service-oriented young doctors, many of them veteran activists from the Student Health Organization (a radical organization of health science students). Some members of the house staff in other departments, and even some in pediatrics who had not been specially recruited for the new program, had little sympathy with the pediatrics project, with its implicit challenge of existing priorities at Lincoln.

The events of June and July rapidly heightened the latent antagonisms among the house staff. With the first appearance of the Think-Lincoln grievance table, a few house staff members claimed to feel "harassed." A larger number were sympathetic to most of the seven demands, but passive, and a minority, centered in the pediatrics department, actively welcomed the first signs of community involvement in Lincoln. The takeover of the nurse's residence and the threat of a police bust, further polarized the house staff. Some advocated mass resignations; others joined the occupation of the nurses' residence. But it was the demands stemming from the death of Carmen Rodriguez which produced the deepest splits. Even many liberal house staff members who (at least verbally) supported the original seven demands of Think-Lincoln, could not accept the challenge to professionalism posed by the demand for the resignation of the chief of obstetrics. If this was what community-worker control meant—the right of nonprofessionals to discipline professionals whom they judged negligent—then many of the house staff found that they were not interested in community-worker control. With, in the week following Mrs. Rodriguez's death, the house staff in the departments of obstetrics and surgery threatened to leave en masse. It came as a surprise when the only house staff who actually resigned (on July 29) were 10 foreign house staff in the department of pediatrics. Publicly, they claimed to have been harassed and threatened by Think-Lincoln people (a charge which LaCot denied), but privately many said they could no longer work with the more radical majority of the pediatrics house staff, which has actively supported the community-worker forces.

The Corporation, represented at Lincoln by
the hospital administration, and Einstein, represented at Lincoln by the professional staff, are not the only institutions challenged by the community/worker struggle. Indirectly, Think-Lincoln and HRUM have also raised serious questions about the role and effectiveness of the hospital workers' unions. Local 1199 of the Drug and Hospital Workers Union and District Council 37 of the American Federation of State, County and Municipal Employees (AFSCME). [See July/August BULLETIN for analysis of hospital workers' unions.] The demand for a minimum weekly wage of $140 is a pointed reminder of 1199's capitulation at the bargaining table last July. Then there is the grievance table, which operates in direct competition with the unions' conventional grievance procedures. Workers who might not otherwise have identified with the community/worker struggle are increasingly turning to Think-Lincoln and HRUM with the kinds of grievances which are usually brought to the unions. If nothing else they have come to respect Think-Lincoln and HRUM's ability to get things done.

So far, the unions' effort to get on top of the situation at Lincoln have backfired disastrously. According to HRUM members, on August 13, 1199 and District Council 37 called a meeting with Lincoln administration, the medical board and HRUM to "discuss the problems at Lincoln." Presumably because they hoped to negotiate some sort of a truce with HRUM, the unions insisted that the meeting be closed to all Lincoln workers except HRUM leadership. A group of clerical workers came to the meeting anyway, mistakenly believing that the meeting had been called to discuss grievances they had been raising, unsuccessfully, with the union, Local 1540 of District Council 37. When the clerical workers interrupted the meeting to raise their grievances, their own union representatives failed to recognize them as union members. According to eyewitnesses, the union leadership charged that the clerical workers were disorderly HRUM supporters and demanded that they leave the meeting. The clerical HRUM members denied any association with the clerical workers but insisted that all workers had a right to be present at the meeting. Enraged by the insistent clerical workers (who by this time probably had become HRUM supporters), all the union leadership walked out of the meeting, followed by the administrators and the medical board.

Left alone together, HRUM members and the clerical workers discussed ways of meeting the workers' grievances, which ranged from the need for air-conditioning in the emergency room to the demand for a $140/week minimum wage. On their own, the clerical workers issued a leaflet which said in part: "We, the clerks of pediatrics emergency, the emergency room and the admitting office have come to the end of our rope. Up to this point we have been working like slaves. We have been pointing out these conditions to our so-called representatives for several months. We have been ignored. . . . We are angry because these inhuman conditions do not allow us to give decent care to our people, the community of the South Bronx."

As of this writing, the situation at Lincoln Hospital is still in flux. Think-Lincoln has made major headway towards winning its demands, but many key demands remain unmet. The grievance table continues to operate without harassment from the administration, but it still has no official power to redress grievances. A daycare center, supplied with food by the hospital, is serving patients' and workers' children in the nurses' residence. Since the hospital refuses to staff the center, Think-Lincoln members are donating their time. The Corporation has completely met two demands: It has begun clearing the site for the new Lincoln, and it has not forced cutbacks in outpatient care. But the Corporation and the Lincoln administration, have shown no sign of meeting the demand for $140/week minimum wage, or establishing a door-to-door program of preventive care, or—of course—turning Lincoln over to community/worker control. The professional staff has not yet acceded to the demand for community/worker surveillance of the abortion program, and the chief of obstetrics remains on the job (though apparently this is only because Think-Lincoln has not continued to press for his immediate resignation).

The pace of the struggle at Lincoln is still accelerating from day to day. New groups of workers, including such usually conservative workers as nurses and clerical workers, and patients are aligning themselves with Think-Lincoln and HRUM. With every day that Think-Lincoln presses for its demands, the bankruptcy of the hospital's existing power structure—the administration, Einstein, and the Corporation—becomes more and more apparent. Even the patients' and workers' official "advocates", the community advisory board and the unions, have shown themselves, by contrast to the insurgent community/worker forces, to be unable or unwilling to struggle for radical change. Unless the community/worker forces are checked by violent repression (which is still a daily possibility), the odds in favor of their eventual victory are mounting. Lincoln may become the first hospital, if not the first multi-million dollar American institution of any kind, to be run by and for the people it should be serving.

Whatever the outcome of the events at Lincoln, it is clear that they have set in motion a new phase of the larger struggle for accountability and community service in the New York municipal hospitals. Inspired by Think-Lincoln, workers at Metropolitan Hospital are manning a patient-and-worker grievance table, and at Fordham Hospital, the newly formed Community Alliance to Improve Fordham Hospital has set up a grievance table of its own. As the chairwoman of Think-Lincoln said, "This is not a one-shot action. It is a long-term struggle, and it has to happen in every institution which is not serving the people now."—Barbara Ehrenreich