WOMEN AND THE HEALTH SYSTEM

Women have a unique relationship to the health system. As patients, they require not only the general health care needed by any adult, man or woman, but also the specialized services related to their reproductive system. As workers in the health system, they make up 70 percent of the entire health labor force. As mothers, they are in most cases directly responsible for the day-to-day care of their children, including health care.

In the past, women have generally seen their problems with the health system in terms of a person-to-person struggle: one woman dealing with a patronizing male gynecologist, a woman health worker struggling with an oppressive supervisor, another woman frustrated in attempts to get good pediatric care for her children. This BULLETIN, focusing on a larger view of these personal struggles, deals with some of the health institutions which control women as patients and as workers. (The issue of pediatric care as it affects women is not discussed here.)

Women as Patients

Of all the factors keeping women in the narrowly defined role of wife and mother, one of the most important has been the biology of their own bodies. The various medical needs associated with the reproductive system make women particularly dependent on the health system. Some of these, such as venereal disease and cancer, affect both men and women; but most are unique to women: vaginal infections, disorders related to the menstrual cycle, and most importantly, reproduction itself. Through most of history, pregnancy, childbirth and childcare have kept women in the home, controlled by men; the most common methods of birth control, withdrawal and later the condom, were directly controlled by men. Increased consciousness on the part of women and advances in birth control technology have helped to bring about radical changes in the status of women.

Fifty years ago, women were imprisoned for demanding contraceptive services; today, the federal government, big business, and the medical establishment are all in favor of birth control. From its beginnings, the Women's Movement has fought for the right of women to birth control and abortion; in 1972, the Movement finds itself on the same side of the fence with John D. Rockefeller III in pushing for these services. The discussion of the birth control movement in this BULLETIN centers on the various interest groups that have been involved in birth control in the US and how the economic and political priorities of the federal government and private business have shaped national policy regarding birth control.

Uncle Sam is now the major provider of birth control services in this country and his concentration is unmistakably on the poor. This raises issues which, though not explored in depth in this discussion, should be emphasized: more and more both poor and middle-class women, and especially third world women, are finding that birth control services are accessible and free while other health services for themselves and their children are not. It is clear that there is a gap between what women want—good comprehensive health care—and what priorities of the health system determine will be provided.
Women as Workers

Women who work in the health system find that they are doubly oppressed, as workers and as women. There are reasons why women make up such a large percentage of the labor force in health institutions. Historically, women have assumed roles of cooking, cleaning, nurturing, and caring for the bodily needs of others; these functions are readily translated into job categories in health institutions. With the exception of the most professional positions, jobs in the health system have traditionally been low-paying. Because other jobs were not available, especially ones that could accommodate their family commitments, women have been forced into these low-salaried positions. The rigid hierarchy existing in health institutions requires a large pool of low-level workers. Women, socialized from birth into passive roles and trained to see their major interest as home and family, have been more easily channeled into narrow unchallenging job categories.

In nursing especially, women have tried to counter this trend by professionalizing the role of the registered nurse. This BULLETIN traces the consequences of this professionalization and the narrow definition of job categories. It points to the rocky road ahead for women health workers if they continue to counter the hierarchical domination of the health system by developing hierarchies and divisions of their own.

Women Struggle with the Health System

As women become aware of how the health system controls their lives, their anger and frustration have grown. This anger has exploded in many different ways, and as a result, women are becoming more and more active in struggles to gain control of their own lives and to take some measure of control over those health institutions which have oppressed them.

Women have long taken major roles in struggles with the health system. They have led community groups fighting for better health care from urban New York City to rural Eastern Kentucky, have organized parents' committees pushing for improved pediatric services from hospitals, and have been a major force in struggles of hospital workers. The BULLETIN has reported on these struggles in the past, but for the first time in this issue, it focuses on the role of women as a distinct group, the Women's Movement, and the Movement's involvement with health issues.

The Women's Movement has concentrated much energy on the struggle for expanded birth control and abortion services. Groups of women have organized abortion and birth control services and referral systems. These activities have been important in providing much needed services. Yet women working in such programs have often become frustrated, realizing that women's health needs extend far beyond birth control and abortion. Thus, many women's groups turned to broader aspects of health care. Women have been the backbone of many free clinics and have even set up clinics serving women exclusively. But again, many women have found this work limited and frustrating, seeing themselves providing patchwork medical care and, by doing its work, actually taking pressure off that larger health system. Some groups have begun to focus pressure directly on the health institutions. There are many problems in doing this. Health institutions seem monolithic in nature. The constituency of the Women's Movement is still largely middle-class women, and while they are dissatisfied with health care, they do not generally use health institutions, such as hospital outpatient departments, for primary health care. Thus, their discontent does not always lead to a natural focus on a single institution. In spite of this, organized groups of women have been able to have some effect on health institutions. In San Francisco, one group makes referrals for all health problems and serves as patient advocates with the institutions. In upstate New York, another group put pressure on a federally funded family planning program and brought about major changes in the development of the program.

A more powerful thrust for change comes when women form alliances with other groups to put pressure on commonly used health institutions. Such was the case in a recent struggle at Methodist Hospital in Brooklyn, discussed in this BULLETIN. As one woman activist stated, "On our own, we're really limited. We need to form alliances with groups of workers inside the institutions and we have to work in coalition with other consumer and community groups. But we have legitimate interests and needs, and if we're organized in groups we can begin to work."

This BULLETIN was prepared collectively by Amy Brodkey, Rachel Fruchter, Margo Levine, Susan Reverby and Jean Sharpe.
THE BIRTH CONTROLLERS

A New York City family planning official recently stated that there are basically four "banners" under which birth control can be "sold":

— the population problem
— the "welfare syndrome"
— the health of women
— the individual right of each woman to birth control

All are legitimate areas of human concern. Birth control is particularly important to women—individually, as a right and as a matter of health; and to the Women's Movement, as a point of struggle for the same goals. However, the concern of those individuals and institutions controlling most birth control programs in the US today is directed more narrowly toward the issues of population and "welfarism." It is not only crucial that women understand the functioning of their own bodies, but it is equally important that they understand interests of those institutions which would offer women these services.

This discussion will trace the development in the US of the birth control movement; examine the roles of various interest groups that have been involved in the movement; and show how those groups have used birth control to further their own interests.

Birth of the Movement

There is a widespread misconception that before the advent of the condom and later, more sophisticated devices, men and women were completely unable to control the number of children they produced. While birth control has become a subject of public debate only in recent years, contraception is certainly nothing new. As early as 1850 BC Egyptian medical experts described mixtures to be rubbed on, swallowed, or inserted to prevent pregnancy. Interest in the subject has never waned.

In the early 1800's a new discussion evolved in Europe concerning economic and social justifications for contraception. Robert Thomas Malthus, clergyman and son of an English country gentleman, became well known for his dire predictions about the population "explosion." Malthus directed his population concerns toward the poor, claiming that their production of too many children caused poverty. Efforts to provide relief to the poor were fruitless or even harmful since making their lives better would encourage them to have still more children. The early birth control movement in Europe and later in the US was deeply influenced by Malthus and most early European groups were called Neo-Malthusian Leagues.

In these years the selection of contraceptives was quite limited. Before the development of rubber condoms provided another widely available contraceptive in the 1800's, most people depended on techniques which had been known for centuries: withdrawal (by far the most widely used), douching with a wide variety of chemical mixtures, intravaginal sponges or cloths (supposedly offering a mechanical barrier to the sperm). Un sophisticted as these methods may seem, people were able to control their own re-
production; when economic pressures made the limitation of family size critical to survival, such as during national depressions, men and women did, in fact, have fewer children.

Until the late 19th century, contraception in the US remained a private affair; there was little public discussion of birth control or mention of the subject in state or federal laws. That period in US history was one of great social unrest and change. In 1873, in an upsurge of Victorian moralism, a self-righteous Anthony Comstock and his Society for the Suppression of Vice joined forces with an equally self-righteous Congress and enacted federal legislation (the "Comstock Laws") prohibiting the mailing, transport, or importing of "obscene, lewd, or lascivious" materials. The laws were passed with little discussion; most of those who voted were not even aware that "all information and devices pertaining to preventing conception" were included in the ban. Thus, contraception came under public control and open discussion and exchange of information about birth control were stifled. Even physicians for a long time could not legally give contraceptives to their private patients. However, many continued to do so privately in their offices, usually without interference.

The late nineteenth and early twentieth centuries, influenced by industrialization and urbanization, were periods of radically changing ideas. There were new ways of thinking about the family, about sexuality, about standards of living. A discussion in the New American Republic at the turn of the century frankly stated that "the modern family" limited its size in order to enjoy a certain "style of living" and "social position" they felt would be threatened by more children. Indeed, the shrinking size of the American family at this period was a matter of great concern to many people. President Theodore Roosevelt, representing one faction of the upper class, insisted that the American people were committing "race suicide." He felt that the family should be the "servant of the state" and should provide children to build national strength. Furthermore, he considered the "worst evil" to be that the "old native American stock" was less fertile than the immigrant population. "Race suicide," more explicitly by the upper and middle classes, formed a basis for struggles against birth control by some individuals interested in maintaining the power of the upper class.

The influences of this period also produced new ways of thinking about the status of women. Feminist reformers had long been struggling for property ownership and the vote. By the early 1900's a few more militant feminists had begun to ask broader questions about women's roles.

The Woman Rebel

One of these was a nurse, Margaret Sanger. In New York's Greenwich Village she became closely associated with some of the outstanding socialists, labor organizers and feminists of the period. Margaret Sanger was very much drawn to the new ideas she encountered and soon joined the Socialist Party. At the same time she also met well known anarchist and feminist Emma Goldman, a long-time advocate of the right of women to contraception.

Margaret Sanger kept up her nursing career. In the course of her work as a visiting nurse, she was called to a Lower East Side tenement to treat a young woman who had tried to abort herself. The physician told the woman not to "get caught" again, that another pregnancy might be fatal for her. His only reply to her pleas for advice about contraception was that her husband should "sleep on the roof." Three months later, Margaret Sanger was called to see the same woman, but this time the abortion attempt proved fatal. As a nurse, she had witnessed similar tragedies time and time again, but that night was a turning point for her. She renounced nursing—"I will not go back to merely keeping people alive . . . I was finished with palliatives and superficial cures; I was resolved to do something to change the destiny of mothers whose miseries were as vast as the sky." Margaret Sanger's answer was to teach women...
about birth control.

Shortly thereafter, Margaret Sanger traveled to France where she felt she could learn more about contraception. There, she learned about methods of birth control and exchanged ideas with French radicals involved in the birth control movement. Returning to the US, she wrote and printed a newsletter, The Woman Rebel, which damned the Rockefellers (she blasted John D. as a "blackhearted plutocrat whose soft flabby hands carry no standard but that of greed"), religion (with which, she stated, the upper class was trying to "drug" the labor force), and marriage (which she described as a "form of property regulation in which wives are sex-chattel"). She also published a controversial and illegal pamphlet discussing various contraceptive techniques and urging women to learn to use them and teach each other. Much of Margaret Sanger's early work was directed toward the emancipation of women. She wrote and lectured passionately of the right of women to be free from compulsory family life and childbearing, free to find other means of fulfilling their lives.

A few of her Greenwich Village friends joined Margaret Sanger touring the US, lecturing on birth control. Although this was a period of great upheaval and activity in the American socialist-labor movement, most individuals involved in it did not see birth control or women's issues in general as being of great importance to their cause at that time.

In 1914 postal authorities declared The Woman Rebel illegal under the Comstock Laws and brought charges against Margaret Sanger. After months of frustrated legal maneuvering, she decided to leave the country to avoid imprisonment. Her year of exile in London was the most critical period in the development of her ideas about the struggle for birth control.

Margaret Sanger's closest associates in England were the prominent English Materialists, the Drysdales, and Havelock Ellis, internationally recognized sexual psychologist. These friends became her tutors and under them she studied not only contraceptive techniques but population economics and eugenics. Her mentors instilled in her the value of prudence and insisted that to be successful in the US, she must concentrate on only one issue—birth control—and leave aside denunciations of capitalism, oppression of women and religion. She also traveled to Holland to visit Europe's first birth control clinic. There she met with birth control specialists who taught her use of the diaphragm. They also insisted that contraception was strictly a medical matter, not something

women could "learn and teach others."

While Margaret Sanger was traveling and studying in Europe in 1915, the birth control movement in the US began to assume organizational form and direction. No doubt influenced by Margaret Sanger's dramatic exile, supporters of birth control formed groups for public advocacy of contraception. Emma Goldman began to speak more explicitly on birth control and lectured all over the US. Most of the organizing was among upper-middle class

women, generally quite conservative, who shunned association with Emma Goldman and other radicals. In 1915, they organized the National Birth Control League, the first American birth control organization. The League worked to change state and federal laws prohibiting birth control.

In 1916 Margaret Sanger returned to the US and went on a national speaking tour to generate public interest in birth control. Back in New York City, she opened the first American birth control clinic in the Brownsville area of Brooklyn. Clinic workers expected police interference and it came soon after the clinic opened. Both Margaret Sanger and her sister, Ethel Byrne, the clinic's co-founder, were arrested, tried, convicted and jailed; the clinic was closed. Their trials and imprisonment, Ethel Byrne's hunger strike and the resultant forced feedings by authorities generated tremendous public sympathy for them and for the birth control movement. As women became aware of the existence of better contraceptives, they became more and more vocal in their demands for these services.

Public interest in birth control increased and the League grew. Margaret Sanger gradually came to the conclusion that to lead an effective struggle to make contraceptives accessible to all women, she would need more support than could be supplied by the handful of political radicals who had taken up the fight. Thus, she joined forces with the women of the
League and became leader of that organization. (The League later became known as the American Birth Control League—ABCL.)

By the 1920's the nature of the birth control movement was set: the ABCL then boasted more than 37,000 members, mostly white, middle-class, native-born Protestant women. Birth control was touted as a way to protect American society from the immigrant masses and the unfit, rather than a step toward better health and the emancipation of women. The propaganda of the birth control movement reflected the eugenics concern of the upper-middle class and underscored the conversion of the movement from a radical program of social change to a conservative program of social control.

The Medical Profession and Birth Control

While Margaret Sanger and upper-middle class women were building a base of support, the reactions of the medical profession to birth control were mixed. Doctors felt that the birth control movement was a propaganda struggle waged by "hysterical women," and associated it with the proliferation of over-the-counter contraceptive devices—"quackery"—and not a subject for legitimate medical interest. However, internationally birth control was coming to be a subject for serious medical investigation, and it was a potentially profitable part of medical practice. The attitudes of most physicians probably represented a mixture of these ideas. As a result, most physicians, even those who gave contraceptives to their private patients, felt that association with the ABCL and Margaret Sanger was professionally damaging. Medical acceptance of birth control was also seriously limited by the fact that, with the exceptions of condoms and the diaphragm with spermicidal jelly, there were no effective, medically safe contraceptives that could be easily used by large numbers of men or women.

During this period, the laws were undergoing changes that allowed licensed physicians more space to prescribe contraceptives legally. New York state law, for several years, had allowed physicians "lawfully practicing" to give out birth control information "for the cure or prevention of disease"; but most physicians had regarded this as applying only to venereal disease. In 1918, a US Supreme Court opinion (regarding an appeal of the case of Margaret Sanger's clinic) specifically allowed a very broad definition of the word "disease," giving M.D.'s a wider latitude by which to judge the legal conditions warranting contraception.

In 1923, Margaret Sanger opened another clinic, the Clinical Research Bureau (CRB), across the hall from the ABCL offices. For legal purposes it was operated as the private office of Dr. Dorothy Bocker, clinic physician. The functions of the CRB included provision of services, but it was to be "above all, a first-class center for medically supervised study of contraceptive techniques." In 1924, Dr. Bocker published a report on over a thousand cases from the CRB. The clinic's wide experience with birth control began to command the interest of physicians.

One of the physicians most interested in the medical study of birth control was Robert L. Dickinson, New York gynecologist and 1920 president of the American Gynecologic Association. At the same time the CRB was established, Dickinson was drawing together a group of New York gynecologists and obstetricians as the Committee on Maternal Health (CMH) for the purpose of carrying on "... a series of impartial, well-staged clinical tests" of contraception. Their reasons for getting involved with such clinical studies were clearly stated by Dickenson, "... we as a profession should take hold of this matter [contraception] and not let it go to the radicals and not let it receive harm by being pushed in any undignified or improper manner ..." As the CRB stood, neither the CMH nor any other "responsible medical organization" would go near it. Dickenson visited the clinic and commented that "to the medical profession in general ... the activity of Mrs. Sanger and her organization are an anathema ... However careful the professional part of the work may be, many feel that the sale of the Birth Control Review on the streets and the agitation for repeal of the law make their movement a dangerous one." Even the ladies of the ABCL were considered "radical" by the cautious and conservative medical profession.

Dr. Dickenson and the CMH attempted to conduct a study of contraceptive techniques by setting up an office to refer women wanting contraceptives to one of seven hospitals in the city that had agreed to cooperate. The program failed; the hospitals were reluctant to give such information and the patients were shy; they wanted a "special clinic."

As the '20's passed into the '30's, medical interest in clinical contraception grew. Margaret Sanger, the ABCL and the CRB remained officially isolated from the organized medical profession, but physicians in New York and all over the country were coming to see birth control as a part of medical practice. Elsewhere in the world, researchers were investigating various new contraceptive methods. The first intra-uterine device (IUD) was developed...
The Pop Pill

G. D. Searle, the company "where 'the pill' began," is trying to keep a hold on the oral contraceptive market. Searle's sales in the mid-1960's were successfully aimed at receptive white, middle-class patients.

Then, noticing the government's interest in the late sixties in family planning and the public's ecological consciousness, Searle found a new way to push the pill. Its latest sales pitch is a series of psychedelic pamphlets on ecology and birth control geared toward humanistic doctors in municipal hospitals, family planning centers, and free clinics who service a third world poor population. The series, entitled The Ecology of Birth Control, includes a full page picture of a crying, obviously hungry, black infant sitting forlornly in a field. Searle makes no bones about which population should be controlled:

"The poor are not simply always with us; they are always with us in ever greater numbers. The caseload of Federal Aid to Dependent Children has climbed to more than 4 million during the past decade, and costs have soared from about $600 million to more than $1.8 billion . . . The problem of helping this segment of society through birth control is complicated by such ethnic [italics ours] factors as high illiteracy among certain groups, as well as suspicion and fear of genocide among some minorities..."

"...Our population may soon outstrip our very finite social, economic and natural resources... Can parents be persuaded to limit their offspring to two replicates who will ultimately replace them without adding to the population? Can those who still insist on large families be persuaded to turn to adoption rather than procreation to fulfill this desire? The responses to such questions will depend greatly on our ability to alter deep-rooted and even time honored public attitudes. In his work with patients and in communities the physician can play a vital role in reshaping these attitudes and beliefs, but his efforts should be supported by a nationwide educational campaign utilizing all communications media and techniques. There is no reason why effective advertising techniques cannot be used to persuade the public to accept contraception and the small family as part of the American way of life."

in Germany and rejected as being unsafe. Japanese and Austrian scientists published new studies on the "safe period" and this became increasingly popular. Public interest in and discussion of birth control was increasing and the movement continued to gain momentum. ABCL members continued lobbying efforts directed toward organized medicine and state and federal legislators.

At this time, the only medically permissible (thus only legal) indications for birth control were quite similar to those used in the case of most abortions today: a large family, endangerment of a woman's health or cases in which pregnancy could mean maternal death. A woman's own wish not to be pregnant was not considered. Physicians gave out information to "deserving" women—those who had done their duty to society by bearing a minimum number of children.

Finally in 1930, a federal court decision allowed "advertisement and shipment of contraceptive devices intended for legal use... for the prevention of disease." This court decision essentially released the supply of contraceptives from the strict control of the physicians. This growing demand for contraceptives, along with the liberalized law, resulted in a booming business in non-prescription methods of birth control. Fortune magazine reported that in the 1930's, American women spent over $219 million annually for contraceptive materials. They further added that "the medically approved segment of this business is pitifully small and as a result, many women are being duped and physically harmed." One critical review stated that "neither the government, the American Medical Association, nor any other organization will give a woman any advice as to the merits of these products."

The liberalized laws, increased public acceptance, growing demands for birth control services by women, demands for medical leadership, and not least of all, the yearly $210 million going to non-medical birth control services—all had their influence on the organized medical profession. In 1937, the AMA issued a cautious statement endorsing birth control in clinics under strict medical supervision. Shortly thereafter, physicians of the CMH won a long struggle with the ABCL and essentially gained control of the Clinical Research Bureau. In the late 1930's, the ABCL merged with the now doctor-dominated CRB to form the Planned Parenthood
Federation of America (PPFA). The new board was, not surprisingly, controlled by male physicians. Slowly but steadily, PPFA began organizing local chapters all over the country, often on the base of already existing birth control groups. Wherever local chapters were organized birth control clinics soon opened.

PPFA was administered and controlled by professional men from the top down. On a local level, the actual work of establishing chapters and clinics was generally carried out by upper-middle class women. While most propaganda of the movement discussed provision of birth control for working-class women, patients who used the clinics were also middle and upper class.

Enter the Populationists or Planning the World’s Family

Early in the 1930’s, federal government agencies were quietly involved in supporting birth control services for certain ethnic groups. Indirectly, federal money went to provide contraceptives to migrant workers in the Southwest and to Indians on reservations. Through state Maternal and Child Health programs, federal funds supported birth control in eight Southern states.

The new governmental concern is based on the assumption that large family size, early, unwanted, out-of-wedlock pregnancies, broken homes, etc., bear the major responsibility for the poor’s state of poverty. In fact, the contrary is known to be true. Poverty and racism with concomitant poor health care and resources are among the major causes of large families, broken homes, illegitimacy, as well as chronic ill health and the premature death of the poor and black.”


Economic pressures of wartime provided an impetus for further federal involvement with family planning. In the early 1940’s, proponents of birth control were hailing it as “an effective weapon in creating a strong people . . . to defend our way of life.” Even more importantly, the war industries demanded workers and with the men overseas, women were needed. It was obviously not efficient to have women workers away from the job having babies. The US Public Health Service pushed states to provide birth control for women in war industries. Women had to be kept on the job line and off the maternity ward.

As the war came to an end and the US became the political and economic leader of much of the world, federal government and private businessmen with interests overseas broadened their interest from the “population problem” at home to that abroad.

Awareness of the world “population problem” was not completely new. The stage had been set years before by Malthus and, in the US, historian Will Durant had warned that to “offset the yellow peril,” the US ought to “spread birth control knowledge abroad so as to decrease the quantity of peoples whose unchecked reproduction threatens international peace.”

A New York Herald Tribune cartoon of 1946 showed, under the title “Freedom from Want,” a figure of kindly Uncle Sam with a basket of food confronting the starving slant-eyed masses with outstretched bowls. Uncle Sam says, “Birth control, maybe you’d better come along.”
“The establishment of a family planning center in a black community which does not have adequate health care facilities... [leads to the conclusion] that white interests are more concerned with causing black babies not to get born, than they are with the survival of those already born.”

—Naomi Gray, testimony to the Commission on Population Growth and the American Future, April 15, 1971
be "... the political arm of the population control movement," to publish ads, lobby government officials and promote public support for government aid to family planning.

**Abroad . . .**

At that time the primary thrust of the populationists was still toward the "teeming masses" of Asia and Latin America. The US government joined the Fords and Rockefellers, who had long taken an active interest in controlling the birth rate of the foreign poor. The US Agency for International Development quietly supported birth control abroad for nearly a decade before the US did so openly at home. In the mid-60's, Congress approved amendments to the Foreign Assistance Act and the Food for Freedom Act, authorizing use of US funds in these programs for birth control. President Johnson firmly established his position in his 1965 State of the Union Address saying, "I will seek new ways to use our knowledge to help deal with the explosion in world population . . ." And further, in his "Birth Control Bargain Speech," he stated that "... less than $5 invested in population control is worth $100 invested in economic growth."

**. . . and At Home**

While efforts to spread birth control overseas continued, developments in the US demanded the attention of populationists and the federal government. The decades of the '40's and '50's brought huge waves of rural Southern Blacks and later, of Puerto Ricans, to settle in urban centers of the Northeast. Unrest in the ghettos and rising welfare and unemployment rolls made the poor all too visible; state and federal governments found it easier to "control" these populations than deal with their problems. This approach was reinforced by sociologists, who asserted that the poor's fecundity contributed to poverty.

The "discovery" of poverty in the 1960's resulted in a proliferation of government agencies to wage the "war on poverty." The Office of Economic Opportunity was one of the first of these. In 1965, it was the first federal agency to make a direct grant for birth control services. Not surprisingly, this initial program was developed in a low-income community in the South.

Along with the "discovery of poverty," the federal government also "rediscovered" mental retardation and entered into this war with a similar battle plan. Government sponsored studies determined that premature births were associated with a higher incidence of mental retardation, and that prematurity was more common among young, poor women having children close together without adequate prenatal care. So, in the '60's, Congress passed the Maternal and Child Health and Mental Retardation Amendments to the Social Security Act, providing funds, at first just for pre-natal care, later with more and more emphasis on birth control.

The interest of the federal government in the profitable domestic effects of birth control was growing rapidly. With that "$5 investment" in birth control, the government could hope to decrease "illegitimacy," cut down the welfare rolls, and lower the number of mental retardates who burden the society. No wonder J. Mayone Stycos, population expert in residence at Cornell University, called birth control "the bargain of the decade."

**Washington Steps up Activity**

Up to now, Congress had had little to say directly about birth control. In the mid-60's Senator Ernest Gruening, with an impressive list of Senate co-sponsors, introduced the first significant domestic family planning legislation to the Congress, calling for establishment of an Office of Population Affairs and for a White House Conference on Population. Its significance lay in the fact that it prompted extensive public hearings which stretched over two years and involved more than one hundred witnesses—leading spokesmen of the populationists, churches, welfare agencies and medicine. The hearings, in the words of supporting legislators, for the first time publicly "documented the existence of a critical family-planning problem in the US," "established the utter inadequacy of the government's response to the problem" and "demonstrated to the Congress the breadth of religious and political support for government action."

By the late '60's Congress was ready to act. Although they still had lingering fears about the reaction of anti-birth control forces, legislators were becoming even more disturbed by rising discontent among the poor in the US, particularly in the inner cities. In 1967, Congress enacted legislation requiring the states to provide family planning services in their public health programs and to women on welfare. Federal funds were allocated to finance family planning legislation to the Congress, calling for establishment of an Office of Population Affairs and for a White House Conference on Population. Its significance lay in the fact that it prompted extensive public hearings which stretched over two years and involved more than one hundred witnesses—leading spokesmen of the populationists, churches, welfare agencies and medicine. The hearings, in the words of supporting legislators, for the first time publicly "documented the existence of a critical family-planning problem in the US," "established the utter inadequacy of the government's response to the problem" and "demonstrated to the Congress the breadth of religious and political support for government action."

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Under the Nixon administration, the birth control offensive expanded. Until now, the government had not, except in small measure, provided contraceptive services directly. Early in 1968, Senator Joseph Tydings, long-time proponent of family planning legislation, started pushing for passage of a major bill committing large amounts of government personnel and funds to domestic birth control programs; discussions of the bill stretched over the next three years. In July, 1969, in the first presidential address ever directed solely to the "problem of population growth," President Nixon proposed the adoption of a national goal to provide, in the next five years, birth control services to all US women who want them.

In the fall of 1969, HEW Secretary Finch established the National Center for Family Planning Services. The Center's impact was not apparent, however, until Congress in 1970 passed the Tydings sponsored Family Planning Services and Population Research Act. This act was the first legislation dealing solely with family planning and sought eventually to provide such services to all poor women. The law also gave the National Center power to coordinate all federally funded domestic birth control programs. Some of the Center's administrators are primarily concerned with family planning as a health service to women. However, they seem overwhelmed by those with a heavy population control orientation.

It is clear that President Nixon is committed to population control. But the private populationists are still marching several paces ahead. The President still opposes abortion. His Commission on Population Growth and the American Future (chaired by John D. Rockefeller III) has called for the liberalization of abortion laws. The Commission also recommends expansion of day-care facilities, liberalized laws concerning voluntary sterilization and increased efforts to provide contraceptives to teen-agers.

Back at the Clinic
PP-WP still occupies the unique position of being the leading provider of family planning information, education and services. As repository of expertise in the country in birth control, it has significantly helped shape legislation and public policy. PP-WP today is a loose conglomeration of local affiliates with a central office and administration in New York City. General policies are set by the national office, but each affiliate is generally free to pursue its own priorities, provide what services it wishes to whom it wishes depending upon the inclinations of the local staff. Nationally, PP-WP now stress-

AIDing the Poor

The Southwest Foundation for Research and Education, a San Antonio birth control research center associated with Planned Parenthood, conducted a study of the side effects of The Pill. Of the 398 women involved, 76 were given "dummy pills." These women were not informed that they were merely taking a placebo. In four months, ten had become pregnant... a not very surprising side effect!

The experiment was financed by grants from Syntex Labs, a major birth control pill manufacturer, and the Agency for International Development (AID). Syntex was interested in the study because publicity about the side effects of the pill has hurt sales. They hoped this study would uncover few side effects in pill users (as it naturally did). AID was interested in the study as part of its long-range strategy to control the "population explosion." As has been true since the beginning of Pill experiments, the recent research was conducted on a non-white women, in this case multiparous Chicano women.

AID has been pushing birth control since 1965 when it supplied 11 percent of the total third world population control funds coming from American sources. By 1968, AID provided about 55% of such funding. In 1965, AID spent $2.1 million; by 1971 its population control budget increased to $100 million. At the same time, AID expenditures in other health programs decreased from $126 to $77 million.

Back home, the San Antonio experiment has caught the attention of women throughout the country. Five thousand copies of the original exposé which appeared in Medical World News (April 16, 1971) were distributed at the Women's Health Conference in New York. Third world women in other parts of the country are contemplating legal actions against those responsible for the irresponsible San Antonio experiment.
They [those in charge of birth control programs] see women as wombs to be deactivated rather than human lives to be fulfilled.

—Rachel Cowan
“Equador: Birth Controlling the People”

es family planning as a right for the health and welfare of mothers and children; local affiliates may choose other emphases. For example, in Chicago the PP-WP affiliate passed a resolution adopting the two-child family as an ideal, one expression of its heavy population-control orientation.

The past ten years have seen significant changes in PP-WP, particularly in regard to its relation to the government. Nationwide, many affiliates are already essentially dependent on federal funding. Others, such as the New York City affiliate, have tried to maintain their independence. But recently, PPNYC has had both internal and external pressure to accept more government money. For example, in the past six years, Medicaid cutbacks in New York City have thrown huge numbers of "medically indigent" women into the lap of PPNYC for contraceptive care. Last year PPNYC felt they could no longer operate without federal funds. They are now seeking federal money for training, information and education, venereal disease screening and treatment, and direct subsidy of patient services.

In Summary . . .

The history of the birth control movement in the US reveals at least two groups with differing motives for their involvement: those who want to make birth control services available to all who want them as a right and matter of health; and those who are using birth control as a way to further their own institutional and class interests. At present, the latter are clearly in control.

Their primary objectives are to:

1. decrease the welfare rolls by decreasing the birth rate of the poor rather than by attacking the roots of poverty;
2. obscure fundamental problems such as poverty and racism, implying that the poor can climb the economic ladder simply by using birth control and having smaller families;
3. control population growth, both at home and abroad, helping to control growing unrest among the poor and maintain the political and economic status quo.

Most efforts of the birth controllers have been directed toward women. Women looking for total health care often find that while birth control services are easily accessible and free, other services are not. Contraceptive care is offered in a specialized clinic that pays little attention to other aspects of health, even closely related ones such as venereal disease or gynecologic problems.

The Women's Movement has been deeply involved in fighting for the right of women to birth control and abortion services. Now they find that the federal government, wealthy businessmen, and almost everyone else seems interested in it as well. As stated by one women's group, "We find that a portion of our fight [for birth control and abortion] has a reactionary as well as a progressive potential. We have been trying to open up laws around birth control and abortion without moving to effectively control its use . . . Although we have gained much in momentum and awareness in the last years, we are perhaps further from real female control of reproduction than we were when we started." Women have long been the consumers of birth control services. They are now beginning to realize that they must control the policies, direction and administration of these programs.

—Jean Sharpe. Jean Sharpe interned at the University of Alabama Medical Center, Birmingham, Alabama and worked for the Emory University Family Planning Program in Atlanta, Georgia, before coming to Health-PAC as a student intern.

References
HALF OF BROOKLYN DESCENDS ON METHODIST

Last spring some members of a women's group called Half of Brooklyn began to turn their energies to health care. Half of Brooklyn is a loosely linked federation of consciousness raising groups and project collectives. The health group decided to focus on their local community hospital, Methodist Hospital.

Many of the women had used Methodist for various services and were well aware of the poor quality of much of its care. In the discussions, they rejected such alternatives as abortion counseling and running a three day Pap smear clinic out of their small storefront. As one member of the group explained, "These projects would have taken up our time in performing services which Methodist should have been providing anyway. Besides, most women here use Methodist, so we realized that we should make our demands on it."

Methodist is in many ways a typical urban community hospital. Located in the ethnically and economically mixed Park Slope neighborhood, this 471 bed facility is the primary source of health care for thousands of Italian, Irish, Jewish, Puerto Rican and Black residents of South Brooklyn. Indeed, it is the only major health institution in Park Slope. The hospital maintains a loose affiliation with the Downstate Medical School of the State University. Like other voluntary hospitals in New York, it receives most of its funds from public and publicly regulated sources, such as Blue Cross, Medicare, Medicaid, the federally funded Maternal and Infant Care (MIC) program, and New York State's Ghetto Medicine Program.

**Homework For Change**

During the summer, women from Half of Brooklyn gathered ammunition. Their research on the services, programs, power structure, funding sources and groups interested in Methodist yielded important information. From personal experience, interviews and a recent City Health Department site visit report, they found more than ample proof of the poor outpatient care dispensed by the hospital. This report, written in June, 1971, complained of "infrequent scheduling of general medical and pediatric clinics . . . lack of patient assignment to a primary physician . . . denial of services to patients without the required fee . . . lack of routine preventive medicine services," and more and more. It concluded that care was provided "almost entirely at the convenience of the hospital . . . intermittent, episodic, uncoordinated and without follow-up."

The occasion of this highly critical report was Methodist's receipt of $207,900 from the 1970-71 Ghetto Medicine Program. This program is administered through the City Department of Health using New York State and local tax funds. The money is supposed to be used by selected voluntary hospitals to subsidize comprehensive ambulatory care to low income patients. The contract between the City and the recipient hospitals also calls for ill-defined, but significant, community involvement in decisions about use of the funds. The women found that Methodist had dealt with this by setting up an Ambulatory Care Service Advisory Committee (AC-SAC), whose 51% racially mixed community membership was hampered by the hospital's withholding of information.

**Women Meet Tenants Group**

At the same time as the women prepared to look closer into the hospital's ambulatory care, they also were aware of opposition to its expansion plans into the neighborhood. Methodist has under way a $90 million development program for staff housing, a parking garage and building of new medical facilities. The hospital has bought up sound, rent controlled brownstones on the adjacent block. These apartments were to be vacated and demolished to build Seney House, a 16 story staff residence, and a three story parking garage.
The proposed complex was severely criticized by a hospital-hired urban planner for its location, exorbitant rent and lack of community facilities. Those tenants not yet vacated, primarily white working people, ex-students and the elderly, in addition to some Blacks and Puerto Ricans, organized themselves into TMHA, the Tenants of Methodist Hospital Association. They began a vigorous opposition to their own harassment and removal and to the hospital's expansion plans.

The women of Half of Brooklyn started to discuss the hospital with the Tenants Association, the more active members of the Ambulatory Care Advisory Committee, and with other groups such as the Park Slope Day Care Collective and the Park Slope Neighborhood Tenants Council. Through intensive leafleting and a protest demonstration at the hospital, these groups were able to attract over 300 community residents of varied ages and ethnic origins to a meeting called by Methodist on September 27th. The hospital's agenda involved creation of a new organization to give the stamp of community approval to Methodist's expansion plans. The agenda of the 300 residents was different: they demanded that the hospital halt its plans to build Seney House and the parking garage, cease harassment of tenants refusing to vacate, improve health care offered the community, and involve the community in any future decisions of the hospital. After being told by Methodist spokesmen that the hospital would not be bound by decisions reached by its own rubber stamp organization, the 300 residents unanimously rejected it and voted "no confidence" in the "hospital administrators and their planners."

The next week the movement was also joined at a large rally by representatives of the Central Brooklyn Independent Democrats, the South Brooklyn Education Committee and the Park Slope Health Planning Council.

Over the next few months tenants held periodic demonstrations to fight evictions and to support particularly harassed families. The hospital has been forced to delay the October demolition of 17 brownstones to March or later. The tenants' strategy has been to advertise their cause and gain broader community support to oppose possible forced evictions by the hospital.

**Women Take On Clinic**

Meanwhile, the women's group has directed most of its attention to health care issues. They began by circulating questionnaires and leaflets, attending clinics at the hospital, and researching the institution. In November the Ambulatory Care Advisory Committee (ACSAC) held an open public meeting for the purpose of nominating new members. At this meeting the hospital agreed to try to extend pediatric clinic hours, set up a child care center in the hospital, and reduce clinic fees. Two of the women have been elected to the ACSAC, and much of the strategy of the women's group is now centered around a struggle for real power in the Advisory Committee. Through it, the community activists have influenced the hospital to institute Pap smears for women in all clinics, a minimal sickle cell anemia screening program, and a policy of assigning patients a primary physician. As one woman stated, "Right now the thing that has to be done is to implement the Ghetto Medicine Law. In the process of doing this we will become more and more involved with other people using and working in the hospital."

Aside from its role in the ACSAC, the women's group wishes to work with other women patients of Methodist Hospital. They want to assist them, educate them on women's health problems, and eventually broaden the base of community involvement in the struggle with the hospital. To this end they have begun small group educational sessions which take place in clinic waiting rooms. They also distribute a "Gyn Checklist" to women in the gynecology clinic.

Many problems have yet to be solved. Mass enthusiasm and unity among groups has waxed and waned. The pillars of the effort remain the women's group and the tenants' association. Although Half of Brooklyn has hoped for a broader base, so far there is not really active participation, except sporadically, of significant numbers of Methodist patients and workers. While the women from Half of Brooklyn recognize the need to speak to the needs and involvement of Methodist Hospital workers, predominantly women, progress in this direction has been slow. Half of Brooklyn women realize that theirs must be a long term commitment to this task. It is by the same token, necessarily premature to proclaim the effort a success.

At a time when the women's health movement seems to be searching for new directions, the events at Methodist Hospital are important to examine. Here a women's health group has engaged in a long term commitment to change a major health institution. The group has formed alliances with other constituencies of the hospital, while maintaining its identity and priorities.

—Amy Brodkey. Amy Brodkey is a medical student at the University of Pennsylvania. She was a summer student intern at Health-PAC.
Womannpower is the manpower of the health field: 75 percent of all health workers are women. Control over this work force is crucial to those who control the health system.

The labor force within the health system is changing rapidly. There has been a vast increase in the number of health workers, from 2.9 million in 1960 to 3.9 million by 1969 to a projected 6.85 million by 1980. The roles they play are also changing: at the turn of the century, 80 percent of all health workers were doctors; today only 12 percent are doctors. New occupational divisions have developed to the point where there are now over 375 independent occupations. With their numerical supremacy, women health workers are a powerful potential power for change.

Womannpower

The predominance of women in the health system developed historically because of two factors. Most jobs in health are dead end, low wage, semi-skilled or unskilled. This kind of work has traditionally gone to women, especially third world women. Also, health care jobs, with the exception of doctors and administrators, reflect the institutionalization of traditional women’s functions: nurturing, caring, cooking, educating, cleaning. In the health system these functions become the jobs of nurse, housekeeper, dietician, clerk, social worker and technician.

Women are 98 percent of registered nurses, 64 percent of cooks, 74 percent of aides and attendants, 98 percent of practical nurses, 94 percent of nutritionists and dieticians, 95 percent of office workers, 80 percent of physical therapists, 75 percent of X-ray technicians, 90 percent of medical technologists and 89 percent of medical social workers. Almost all dental hygienists, medical librarians and clerks are women.

While women fulfill the “feminine functions” men make the decisions. Men are 93 percent of doctors, 90 percent of chiropractors, 98 percent of dentists, and 80 percent of hospital administrators. There is even a feminine role for woman doctors. The phrase “a woman’s place is in the home” has been changed to “a woman’s place is in pediatrics or child psychiatry,” according to one woman doctor.

Wage differentials for the same job follow sex lines. In almost every field, especially where women overwhelmingly predominate, the wage difference is great. Thus the 145,942 women practical nurses receive on the average ten dollars less per week than their 3,350 male counterparts. Men’s and women’s salaries were equal in only one field: medical technology. Women health workers on the top suffer as well. Women doctors tend to take salaried institutional positions rather than go into higher paying private practice. And they can also expect less advancement.

A 1969 Department of Labor study of hospital wages demonstrates the following weekly wage differentials:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapists</td>
<td>$166.50</td>
<td>155.50</td>
</tr>
<tr>
<td>X-ray Technicians</td>
<td>131.00</td>
<td>116.50</td>
</tr>
<tr>
<td>Food Service Supervisors</td>
<td>137.50</td>
<td>96.00</td>
</tr>
<tr>
<td>Housekeeping Chiefs</td>
<td>154.50</td>
<td>96.00</td>
</tr>
<tr>
<td>Practical Nurses</td>
<td>108.50</td>
<td>98.50</td>
</tr>
<tr>
<td>Nurses’ Aides</td>
<td>82.00</td>
<td>75.50</td>
</tr>
</tbody>
</table>

Why Health Work?

Columbia University manpower economist Eli Ginsberg describes the predicaments of the health system: “A field which
attracts a disproportionate number of women, many of them young, will tend to have the following characteristics: a low wage scale, heavy turnover, excessive training costs, and relatively little accumulation of skill through experience." While the description may be true, Ginsberg puts the burden of blame for these problems on women rather than on the low wages and alienating work conditions of the health system.

The "disproportionate" number of women reflects the fact that women have few other choices. As one medical social worker said, "What do you do as a woman? The options were to be a nurse, teacher or social worker." In interview after interview women health workers in New York City cited economic necessity as the key factor in choosing a health career. One nurse said, "We didn't have the money for me to go to college. My mother was a nurse and had gone to a diploma school, so I decided to become a nurse as well." If society gives women in general few options, it gives even fewer to poor and third world women. "What else could I do?" asked one Harlem Hospital nurses' aide.

**Turnover**

Although most women who work in the health system do so out of economic necessity, there is nevertheless high job turnover. In 1957, the turnover rate for all workers in nursing (including practical nurses, registered nurses, aides, attendants and orderlies) was 60 percent, compared with 18 percent for women teachers in the public schools. This turnover reflects many factors.

- **Dual Roles**—Women in health face the same tensions that confront women in other fields; they must work to earn money; yet they are expected to have children and care for their families. One ward clerk said, "I have a 15-year-old daughter. She's a good girl, but if she started getting into trouble I guess I'd have to quit and stay home."

  Women tend to enter the labor force before their children are born, to leave work while they are growing up and to re-enter after the children are either in school or out of the house. The largest number of non-working nurses are 30 to 34 years old. But both the number of women working and the length of their work experience are increasing. The percentage of mothers who work has risen twice as fast as the rate of all working women between 1940 and 1957.

Yet, the health institutions make very few provisions for a woman's other responsibilities. Child care facilities and paid maternity leave are virtually non-existent. Some special programs for part-time residencies and internships have been instituted for women doctors who have children; but neither day care nor housing close to the hospital is available for most health workers. In 1969, only 2 percent of the children of all working mothers in the labor force were in the limited number of day care centers; most mothers must find make-shift personal solutions or lose their income to stay home with their children.

- **Working Conditions**—Most women health workers face low paying jobs and years of frustration and alienation. Low wages are only part of the problem.

  In study after study registered nurses stated clearly that if they leave the field, it is because of the vast discrepancy between what they were trained to do and what they are allowed to do. Said one nurse, "We're really like secretaries pushing papers around. All we do is dispense pills to the patients. Giving medications gets to be boring. The aides are the ones who really work with the patients." One nursing educator with twelve years of nursing experience said, "Let's face it, nursing is a rotten job. You have no control over hours, you rotate shifts, work weekends and holidays. You get moved from floor to floor. Sometimes you're the only one with fifty patients and yet the supervisor comes in and yells at you and you think, what do they expect from me?"

Lack of fulfillment is built into all levels of hospital work. Narrow and specific job definitions mean people do the same repetitious tasks day after day: stenographers type medical records, IV technicians start IV's, hematology technicians count blood cells. Doctors, who may do a variety of tasks, have transferred many of the mundane tasks to other workers, mainly women. It is difficult for other health workers to break out of their narrow slots. One cardiology technician said she had not been taught anything about cardiology and that the doctors refused to answer her questions.

- **Hierarchy and control**—Narrow job definition is reinforced by hierarchical control in the health system. Lucille Kinlein, a nurse writing in the January, 1972 issue of Nursing Outlook, said "So often I knew the patient better than the physician and had scientifically based reasons for wanting to initiate a certain action—but I was prevented from doing so without being given equally valid reasons. The goal seemed to be to keep the institution operating at a smooth pace and to placate the other professional people, rather than to help the patient to meet his needs."

Nor is it just nurses who have no control over their work. The health system is a rigid caste system. Economist Martin Karp
noted: "In no other industry is the 'pecking order' more evident." The result is that because workers cannot vent their anger against the people above them, they take it out on those below them or on the patients. Narrow job roles and rigid hierarchy lead to frustrations and divisiveness between health workers.

The caste system in health reflects not only divisions between job categories or sex, but deeper divisions of class and race. This, of course, serves the interest of those who run the health industry. The development of this hierarchy and the concurrent problems it brings for all women health workers, is epitomized in the history and current difficulties facing the nursing field.

**Florence Nightingale: Gentlewomen and Domestic Servants**

In the nineteenth century, hospitals were part of poor houses. There was no professional nursing; poor women, many times themselves inmates of the poorhouses, did what little nursing there was. Nursing as a distinct profession began on the battlefield where disease often killed
more soldiers than did bullets. During the Crimean War of the 1850's, Florence Nightingale and a group of dedicated women proved that good nursing care could drastically decrease the mortality rate among soldiers. Nightingale returned to England after the war to introduce her concepts of professional nursing to English hospitals.

Stratification characterized the system from the beginning. The Nightingale system trained women in two categories which reflected English class divisions: "lady probationers" and regular nursing students. The lady probationers were to be gentlewomen of middle and upper class backgrounds who would have "those qualifications which will fit them to become superintendents." The regular students were to be "... well-educated domestic servants and ... the daughters of small farmers ... tradesmen, artisans ... who have been used to household work." These women would become regular hospital nurses.

Because medicine was still closed to women at this time, many headed for nursing. Nightingale was clear that nursing was to be a separate function, a co-profession to the doctors; but, she was not, she reassured the worried physicians, training "medical women."

**US Developments**

Hospitals in America quickly saw the advantages of training nurses. Student nurses could be used to fill the hospitals' nursing needs; and better still, they didn't have to be paid beyond room and board. Between 1880 and 1900 the hospital nursing schools in the US grew from 15 schools with 323 students to 432 schools with 11,000 students. Since cheap student labor provided the bulk of nursing care, hospitals did not hire their students after graduation. Besides, most health care was delivered at home and thus graduating nurses tended to go into private duty nursing in the home.

As with medicine at this time, there was no uniformity or minimal standard for nurse training. The nursing leadership began to feel the need for uniform admissions standards and curricula in nursing schools. Above all, they sought the legal recognition of nursing through passage of nurse practice laws and the registration of nurses.

Thus, in 1894, leaders of nursing schools organized the Society of Superintendents of Training Schools for Nurses which in 1912 was to become the National League for Nursing Education (NLN). Recognizing the need for a more broadly based group, a Nurses Associated Alumnae of United States and Canada was organized in 1896. The NLN was primarily concerned with educational standards; the Nurses Associated Alumnae with work conditions and the registration of nurses on a state-by-state basis. In 1911, the alumnae group became the American Nurses Association (ANA). The overarching concern of both organizations was the establishment and upgrading of nursing standards and the recognition of nursing as a defined profession. The result of this professionalization was the creation of an internal hierarchy within nursing.

**Divisions Begin**

Concerned with the increased costs of professional nursing, hospitals supported differentiation within the field. In 1907, the American Hospital Association (AHA) advocated distinction between three grades of nurses: the executive or teaching nurse, the bedside nurse, and the attendant or subsidiary nurse. The AHA suggested that all categories be licensed, but that the first two be classified as registered nurses, while the third be called by some other title. The AHA study had little influence at the time, but it clearly indicated the hospitals' interest in fostering the divisions within the nursing profession.

World War I increased the need for health workers and raised questions about their training. After the war, the Rockefeller Foundation convened a conference which led to a study of nursing and nursing education. Released in 1923, the study, called the Goldmark Report, suggested that nursing become part of a collegiate program. The report also recommended that auxiliary personnel be trained in shorter periods of time to carry on some of the less important nursing functions. The Goldmark Report attempted to do for nursing what the Flexner Report in 1910 did for medicine. The latter resulted in the upgrading and standardizing of medical training by putting it into a university setting. Following the Goldmark Report, nursing programs at Yale and several other universities were established.

"Even the most cursory examination of nursing's history reveals a tragic melodrama of dependency, rejection and exploitation."

—Virginia Driscoll, NYS Nurses' Association
During the Depression, droves of private duty nurses were unemployed and many hospital-based nursing schools closed. During World War II, hospitals began to hire nurses; the increased cost led to the creation of a new subdivision in nursing—the "practical or vocational" nurse.

By the post-war period, studies by the American Nursing Association recommended that there be a further increase in auxiliary nursing personnel on the one hand, and an upgrading of registered nurses on the other. Thus the hierarchy in nursing became more elaborate and rigid. Bedside nursing was to be done by the practical nurse and later by a new, lower category called the aide. Meanwhile RN's tried to separate themselves from "lower" nursing categories by greater specialization.

Professional vs. Technical Nurse

By 1964, seeds of the division planted by Florence Nightingale in the nineteenth century had come into full bloom. Indeed, divisions multiplied even within the ranks of registered nurses. The ANA recommended two different kinds of programs to train registered nurses: a four-year baccalaureate college program for "professional" nurses and two-year community college associate degree and hospital-based diploma programs for "technical" nurses (see BULLETINS, March, 1970 and September, 1970).

The consequences of these new divisions were not long in coming. In the early 1960's 84 percent of all nurses had been trained in hospital-based diploma schools; by 1970 the figure was down to 52 percent. Hospital schools began closing while new associate degree community college programs expanded. In 1969, 27 percent of all nurses were trained in associate degree programs, 21 percent in the baccalaureate programs.

Nursing authorities see a wide difference in the functions of these two types of nurses. According to Martha Rogers, head of New York University's Division of Nurse Education, "Baccalaureate graduates in nursing are no more interchangeable with associate degree and hospital school graduates than are dentists with dental hygienists or medical doctors with physician assistants." Supervisory and administrative jobs go to baccalaureate nurses, even those fresh out of school. The divisions are racial as well as functional: In 1968-69, 10 percent of associate degree nursing students were black, while black students were only 5 percent of those in baccalaureate programs. Black graduates of these programs actually dropped from 9.7 percent in 1962 to 4 percent in 1966.

Divided We Fall

With expanding institutions and developing technology, division of labor in the health field has been irresistible, as it has in other industries. For the majority of health workers, this has meant specialized, alienating, often low-paying jobs. This increasing division has threatened the nursing profession.

Rather than challenging this policy or the hospital hierarchy, the nursing leadership has sought, throughout history, to preserve the power and status of "professional" nursing by creating its own subdivisions and hierarchy. The result has been to divide the interests of all health workers, and to so narrow the functions of professional nursing as to threaten its existence.

Today the nursing profession feels it is being squeezed from all directions. The explosion of "new careers" and manpower training programs is turning thousands of technical and paraprofessional health workers onto the job market. There are now over 250 new job categories such as medical records technician, dietetic technician, social health technician and family health worker—many of which fill traditional nursing functions (see box, page 20). And many are low-paid, dead-end jobs going, by and large, to third world women.

Many nurses are now turning to the gray area between traditional doctor and nurse functions—taking medical histories, screening patients, supervising routine care, etc. Nurses in this role are called nurse practitioners or "extended" nurses. There are now over fifty different training programs for "extended nursing" in pediatrics, obstetrics, anesthesiology, and other specialties.

The only problem with this tack is that it runs headlong into another new vocational—the physician assistant. Developed to utilize the experience of ex-military medical corpsmen, physician assistants "provide patient services under the supervision and direction of a licensed physician." Rather than advocating that nurses become physician assistants, however, the ANA has attempted to split the hairs that differentiate the two functions. "The term physician assistant should not be applied to any of the nurse practitioners being prepared to function in an extension of the nursing role," stated a December, 1971, ANA position paper.

Meanwhile more sweeping reforms of the nursing field are afoot. Dr. Henry Silver, developer of one of the first nurse practitioner programs, and Patricia McAltee, a nurse, reporting on a study supported by the Carnegie Corporation,
<table>
<thead>
<tr>
<th><strong>Original RN Functions and Activities</strong></th>
<th><strong>Allied Health Worker Now Providing the Service</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet therapy</td>
<td>Dietician and dietetic aide</td>
</tr>
<tr>
<td>Social service—related to disability, hardship, etc.</td>
<td>Medical social worker</td>
</tr>
<tr>
<td>Central supply service—cleaning, wrapping supplies, sterilizing packs, etc.</td>
<td>Central supply technician and worker</td>
</tr>
<tr>
<td>Medical records—maintenance of charts, records, discharges, abstracts, etc.</td>
<td>Registered medical record librarian</td>
</tr>
<tr>
<td>Recreation therapy—activities, games, amusements, reading materials, etc.</td>
<td>Recreation therapist and volunteers, candy strippers, etc.</td>
</tr>
<tr>
<td>Rehabilitation therapy</td>
<td>Physical therapist, occupational therapist</td>
</tr>
<tr>
<td>Operating room, Delivery room—scrub nurse, circulating nurse, etc.</td>
<td>Operating room technician</td>
</tr>
<tr>
<td>Bedside nursing</td>
<td>Licensed practical nurse, aide, orderly, volunteer</td>
</tr>
<tr>
<td>Nursing specialties—recovery room, post-operative nursing care, monitoring devices, hypothermic techniques, uses of pacemakers, oxygen tents, cannulae etc.</td>
<td>Inhalation therapist, bio-medical engineering technician</td>
</tr>
<tr>
<td>Employment interviews (for nursing service)</td>
<td>Personnel director</td>
</tr>
<tr>
<td>Administration (nursing unit)</td>
<td>Ward manager and ward secretary</td>
</tr>
</tbody>
</table>


advocate dropping the term "nursing," with its feminine connotations, in favor of "health care practice," to attract men to the field. Schools of health care practice would offer two curricula. "One would prepare them as providers of care, comfort and nurturing, the other for the expanded scope of health care and services, involving a wide variety of direct care functions and activities" (American Journal of Nursing, January, 1972). Although both men and women would attend these schools, it seems clear which curriculum will be set up for whom.

In light of the pressures and threats to the profession, nurses are becoming more militant. Many are now turning to a union approach, although there is ambivalence about whether they should join traditional unions or make the ANA their bargaining agent. This approach may be more positive if it unites nurses with other hospital workers. But so far it has tended to be a defensive maneuver for nurses to tighten their professional status and to keep the rigid hierarchy.

**United We Stand**

The narrow professionalism of the nursing leadership has boxed nurses into a corner. As they fought for higher wages and more skilled roles, nurses have found themselves threatened from below by unskilled, cheap labor and new technology; and insofar as they have succeeded, they now find themselves threatened from above by men coming into the field to take advantage of the higher wages and status. And the competition and division between job functions, social classes, races and sexes has worked only to the advantage of those who run the health institutions.

It would seem that to achieve job control, status, decent wages, and some measure of job fulfillment, professional nurses must join with health workers at all levels in a struggle which would make these goals possible for all.

—Susan Reverby