1 Sterilization:
WOMEN FIT TO BE TIED. Medical abuses are consistent with US government policy.

7 Health Manpower:
BIGGER PIE SMALLER PIECES. The growth of health workers has far outstripped most industries.

14 Media Scan:

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Sterilization

Sterilization abuse is not the exception but the rule. It is systematic and widespread. Women are often misled about the dangers of surgery, misinformed about its permanence and coerced while under the stress of labor or abortion.

Newspapers abound with horror stories of abuses in the health system—Medicaid Mills, nursing home ripoffs, profiteering in the drug industry, unnecessary surgery and clinical research on unknowing public patients. Generally these instances are treated as illegitimate, illegal aberrations of an otherwise decent health care system.
Yet any careful examination of these so-called abuses would reveal that each can be causally connected to particular aspects at the core of our health system. For example, Medicaid Mills and nursing home scandals are the literal extensions of Medicaid and Medicare financing (see BULLETIN, September/October, 1974), while drug company profiteering is the consequence of a health system that allows and encourages profits to be made from human misfortune. The fee-for-service system with its concomitant lavish remuneration of surgeons is the only possible explanation for all the unnecessary surgery performed. The abuses of clinical research are a function of the imperative of the medical system that often sets teaching and research before patient care.

Sterilization abuse stems from a combination of factors inherent in the health system plus one critical additional factor. Besides resulting from teaching and research imperatives, profitmaking and the fee-for-service system, such abuse is the most widespread example of medicine as an instrument of social control. Sterilization is the most extreme form of birth control and birth control is official US government policy. In 1973 there were about 500,000 sterilizations performed on American women. (1)

How It's Done

Female sterilization is accomplished by either tying, obstructing or removing the Fallopian tubes (tubal ligation) or by the removal of the uterus (hysterectomy). (2) Tubal ligations are done by either traditional surgical techniques, reaching the tubes through the vagina or the abdomen, or by the newer endoscopic procedures, in which a tiny incision is made in the abdominal wall and the tubes are cauterized or clipped. The traditional surgical procedure requires a two-or-three-day hospital stay, while the endoscopic methods can be performed on an outpatient basis.

None of the sterilization methods is innocuous. Each procedure is associated with some physical and psychological side effects. Estimates of mortality and morbidity are widely varied, but there is general agreement in the medical literature that some risk is attendant to each procedure.

The method of postpartum sterilization most commonly employed in the US is surgical abdominal tubal ligation performed within 48 hours of delivery. Because the peritoneal cavity must be entered, this procedure is classified as major surgery. The mortality rate from this operation is 25 per 100,000 women. (3) It is associated with a postoperative morbidity of from 2 to 4 percent, primarily from infection or bleeding. (4) The endoscopic method most commonly used is laparoscopy, in which a needle is inserted into the abdominal cavity, through which carbon dioxide is pumped until the abdomen becomes taut and the Fallopian tubes are caught with forceps and cauterized. The death rate following this operation is variously estimated to be from 14 to 30 per 100,000 women. (5) There are fewer serious side effects than with the other common sterilization methods, but from 1 to 2 percent of women experience bleeding, uterine perforation, accidental burning or bowel trauma. (6) Less serious physical side effects include abdominal pain or pain during menstruation (20 to 30 percent (7)) and increase of menstrual bleeding (from 10-40 percent). (8)

Psychosexual complications from female sterilization are widely reported. A 1973 study shows that the actual prevalence of regret among sterilization patients may be as high as 25 percent. (9) Another recent study reported that "about 40 percent of pelvic operations in women may be followed by a condition having certain features characteristic of agitated depression beginning about one month after the operation and lasting more than six months." (10) As long ago as 1965 a report appeared in Obstetrics and Gynecology noting that "A year after the operation, successful emotional adjustment seems to be correlated, in a majority of women, with the presence of one striking unrealistic fantasy: the ability to become pregnancy [sic] again!" (11)

The complication rate resulting from hysterectomy is 10 to 20 times higher than that associated with tubal ligations. (12)
Death from this major surgical procedure occurs 300 to 500 times for every 100,000 operations. (13) Similarly, morbidity is much higher from hysterectomy than from other sterilization techniques. One study found a 22 percent morbidity rate, while other estimates range from 10 to 34 percent. (14)

While a hysterectomy is by far the more dangerous sterilization method, it has the advantage of being 100 percent effective, as opposed to a tubal ligation, which will fail one out of every hundred times. (15) The risks of tubal ligation become more significant in light of comparable risks and benefits from other types of birth control. The 1 percent failure rate of the pill is the same as that of tubal ligations while IUD's fail in about 2 percent of cases. (16) The other mechanical contraceptive techniques are considerably less successful in preventing pregnancies. However, the physical and psychological risks associated with birth control methods short of sterilization are minimal compared with those of tubal ligations or hysterectomies. The pill is held responsible for one death in 200,000 users. (17) Yet in 1970 the Food and Drug Administration became so concerned over the potential dangers of the pill that it required every prescription to be accompanied by warning literature. (18)

**Sterilization on the March**

Sterilization is both the most dangerous birth control method and the fastest growing. The most comprehensive sterilization statistics are prepared by the Association for Voluntary Sterilization (AVS). Though these estimates must be read skeptically because of the vested interest of AVS in promoting sterilization, the trends they reflect are comparable with those seen in other reports. Since 1970 the figures show an almost three-fold increase in the incidence of female sterilization, from 192,000 in 1970 to 548,000 in 1974. (19) Hospital and local surveys report similarly spectacular increases. At the University of California-Los Angeles County Medical Center there was a 742 percent increase in elective hysterectomies and a 470 percent increase in tubal ligations in the two years from 1971 to 1973. (20) Dr. Richard Hausknecht reported that the number of sterilizations performed at Mount Sinai Hospital in New York City has increased 200 percent since 1970. (21)

The situation as it was in 1970 is shown in the National Fertility Study, conducted by the Office of Population Research of Princeton University under a grant from the US Department of Health, Education and Welfare (HEW). (22) A total of about 1.43 million married American women under 45, who were neither pregnant, postpartum, trying to get pregnant or naturally infertile, were sterilized in 1970, (8.5 percent of this group). That average percentage increases from young to older, white to Black and educated to uneducated. Only 5.6 percent of college-educated white women were sterilized and 9.7 percent of comparable Black women. Among women with less than four years of high school, 14.5 percent of white women and 31.6 percent of Black women had been surgically sterilized. Relatively few women under 30 reported they were sterilized in the 1970 survey specifically, 2.8 percent of white women and 5.0 percent of Black women under 30 had been sterilized. As would be expected, a larger proportion of older women had been sterilized, specifically 8.4 percent of white women and 32.5 percent of Black women.

There is much evidence to suggest that the increase in the number of sterilizations has fueled a trend toward the sterilization of younger women with fewer children. A recently published study of a large hospital in St. Paul, Minnesota showed that the ratio of tubal ligations to births increased from 1:9.2 in 1968-69 to 1:4.3 in 1971. (23) In the earlier period 19.7 percent of the women were under 25, whereas three years later 29.7 percent...
were 25 or younger. The median age of women sterilized in federally financed family planning programs in 1973 was 28; 4 percent of such women were under 20 and only 38 percent were over 30. (24) Even among the relatively poor women served at these clinics racial disparities are apparent. More than half of the patient population was white, but only 40 percent of those sterilized were white. At the same time, about one-third of patients were Black, while 43 percent of the sterilized women were Black.

**Medicine Joins the Bandwagon**

The editors of *Family Planning Digest*, the official publication of HEW's National Center for Family Planning Services, wrote in 1974: "As US professional attitudes change, it is possible that we may see sterilization become as important in family planning in the fifty states as it already is in Puerto Rico." (25) (Of married Puerto Rican women, aged 15 to 44, 35 percent are sterilized; two-thirds of the women are under 30. (26)) Surveying the attitudes of mainland doctors, particularly gynecologists, it is difficult to see how much further in that direction they could change.

Official accommodation to liberalization of sterilization practices in the US came in 1969, when the American College of Obstetricians and Gynecologists (ACOG) withdrew its age-parity formula. (27) by this rule of thumb sterilization could only be performed on a woman whose number of living children multiplied by her age equaled 120, as, for example, a woman age 30 with four children. In 1970, the ACOG dropped its widely used recommendation that the signatures of two doctors plus a psychiatric consultation be obtained prior to performing a sterilization. Dr. Don Sloan, Director of Psychosomatic Medicine at Metropolitan Hospital, a municipal institution in New York City, used to receive two or three referrals per day; since 1970 he has gotten about one per month.

The liberalization of sterilization guidelines opened the floodgates to abuse. Although some of the increase in the number of operations performed is due no doubt to increased demand, much of it is the result of misinformation and coercion. Women are often convinced to undergo sterilization with a soft-sell pitch. Describing laparoscopies as "bandaid surgery" and calling tubal ligations "a stitch," doctors minimize the dangers involved. As one noted, women find the procedure more acceptable if the term "operation" is not used. (28)

Gynecologist/obstetricians are surgeons, and with the birth rate falling there are fewer and fewer opportunities to learn and practice their surgical skills. "The early 'rewards' for doing more operations on the poor and disadvantaged in the form of residency certification and specialty board qualification are translated, after training, into financial rewards wherein, the more you cut, the more money you make," noted one report. (29)

Many young gynecologists in training have united their professional needs and their political ideas. Two recent surveys are revealing. Doctors were polled about their attitudes towards contraception for public versus private patients. Of the doctors queried in Detroit, Grand Rapids, West Virginia and Memphis only 6 percent said they would recommend sterilization as the method of choice to their private patients but 14 percent chose sterilization as the first method they would push with public patients. Additionally, 94 percent of the gynecologists favored compulsory sterilization of welfare mothers with three illegitimate children. (30) Sterilization is pushed for low-income and welfare women because many doctors believe that the poorer the woman, the less likely she is to use other methods successfully. (31)

It can at least be argued that a tubal ligation is relatively simple, cheap surgery. Hysterectomy is not. But there has been a tremendous upsurge in the number of hysterectomies for the purpose of sterilization, or hystersterilizations, as the procedure is euphemistically called. The acting director of OB/GYN at a municipal hospital in New York City reported, "In most major teaching hospitals, in New York City, it is the unwritten policy to do elective hysterectomies on poor Black and Puerto Rican women, with minimal indications, to train residents. . . . At least 10 percent of gynecological surgery in New York City is done on this basis. And 99 percent of this is done on Blacks and Puerto Rican women." (32) The same situation prevails at other public hospitals. An OB/GYN resident at Boston City Hospital commented: "We like to do a hysterectomy, it's more of a challenge. . . . You know, a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for a junior resident . . . good training." (33) A staff doctor at Los Angeles County Hospital contributed to a dis-
discussion by saying: "Let's face it, we've all talked women into hysterectomies who didn't need them, during residency training." (34)

Training imperatives and political attitudes account for some of the increase in hysterectomies. A third, compelling reason, is greed. At Albert Einstein Medical School's College Hospital in New York, a hysterectomy will cost $800, while a tubal ligation costs about $250. Some private doctors get as much as $1,000 to perform a hysterectomy. (35) Dr. Rosenfeld points out that "Once the doctor sells a woman on sterilization, it is easy to move it up to a hysterectomy." (36) Patients who ask about the effect of a hysterectomy on their sex life are told cavalierly at one major hospital in New York City, "We'll take away the baby carriage, but we'll leave you the playpen." (37)

**Signing on the Dotted Line**

Sterilization is unlike every other form of birth control. It is for all intents and purposes irreversible. A woman making a decision of this magnitude should have access to all pertinent information concerning the risks and benefits and the ability to make the decision in an atmosphere free of coercion. This is rarely, if ever, the case.

A sterilization consent form is frequently thrust in front of a woman while she is in the midst of labor. A resident at LA-USC Hospital said, "I used to make my pitch while sewing up the episiotomy when the anesthesia started wearing off." (38) According to another doctor at the same institution, "Some house staff would routinely ask women if they wanted their tubes tied during labor." (39) Sterilizations are also performed concur-
rently with abortions, with all the attendant trauma that that procedure entails. (40)

One indication of sterilization's acceptability to those who are truly informed is demonstrated by a 1972 study conducted by Albert Einstein College of Medicine. Surveying birth control practices of obstetricians and their wives, the study revealed that 4 percent of these women were sterilized, as compared to 12 percent of a comparable group of white women in the general population. (41)

**Others Join the Chorus**

The most common source of information regarding sterilization is the booklet "Voluntary Sterilization for Men and Women" prepared by Planned Parenthood-World Population (PP-WP). (42) There is no mention at all in the booklet of the potential risks or disadvantages of sterilization. In fact, the impression promoted is all wine and roses: "Women can't detect any difference from before the operation. Actually, they often find sex is more pleasant because there is no reason to worry about becoming pregnant." Not only does the pamphlet ignore any discussion of the potential for severe psychological problems, as discussed previously, but it never even mentions the physical risks nor does it compare the efficacy of tubal ligations with other forms of birth control.

The sterilization booklet is inadequate even by comparison with other Planned Parenthood literature. The booklets on the pill and IUD's at least mention some of the risks involved and suggest that women ask their doctors for additional information. The sterilization booklet is incomplete and misleading to a dangerous degree.

There is evidence that the necessary modifications of the Planned Parenthood booklet would not discourage those who were actually seeking sterilization with a full understanding of its implications. The argument that couples seeking sterilization will be "scared off" or become "unnecessarily worried" by informed consent is questionable. Dr. F. J. Hulka of the University of North Carolina School of Medicine recently wrote concerning counseling of couples applying for sterilization: "If they have had two children and are in their mid-20s, an increasingly common pattern, I ask if they know that abortions are available. These couples are often worried both about pregnancies and surgery but are willing to have surgery because they fear pregnancy more. We tell them that if, despite use of their contraception method, pregnancy occurs, we will terminate this unwanted pregnancy and do a tubal ligation at the same time, as an out-patient procedure. Very few couples are dissuaded from elective sterilization by this offer, however, because most patients seeking sterilization will not contemplate even the possibility of pregnancy. 'Please stop our worry now,' they plead." (43)

Even if it were established, however, that full information would "scare" potential sterilization patients, it is clearly their decision to make for their own reasons, whether their fears be grounded in medical fact or not. The professionals' argument evidences a paternalism that has been characteristic of the physician-patient relationship almost since its inception.

The efforts of Dr. Bernard Rosenfeld to alleviate the shortcomings of the Planned Parenthood booklet are documented in correspondence between him and Dr. A. J. Sobrero, permanent member of the PP-WP National Medical Advisory Committee. Concluding the correspondence, Dr. Sobrero wrote: "... none of Planned Parenthood's materials is supposed to assume the burden of informing the prospective client of the benefits, risks, effectiveness, and mode of use of any method of contraception. ... Again let me stress that none of the printed material has been prepared nor is being advocated for use for informed consent." (44) The Planned Parenthood booklet, however, is the only source of information available to patients at many public hospitals. (45) (In response to the criticism mounted by Dr. Rosenfeld and others, the Planned Parenthood book has recently been revised, but the tone of the pamphlet has not changed.)

Indicative of the pervasive misunderstanding concerning sterilization is the discussion in Our Bodies, Ourselves, the otherwise carefully written book published by the Boston Women's Health Book Collective. (46) The dis-Continued on page 10
Health Manpower

Health care is one of the largest and fastest-growing sectors of the American economy. In 1971 there were about 4.5 million people working in hospitals, nursing homes, doctors' offices, health departments and clinics. (5) This total represented more workers than those employed by the auto and electronic industries combined.

EMPLOYMENT IN THE PRIVATE SECTOR: SELECTED INDUSTRIES 1960-1972 (in thousands)

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<td>1,548</td>
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*Does not include those employed by government.


The continuing shift of focus of health-care delivery from solo-practice doctors to institutional settings provides the framework within which to understand the growth and development of the health-care workforce. Following the course of industrialization in the manufacturing sector, the health-care industry increasingly depends upon semi-skilled and unskilled workers. Contrary to popular perceptions, the bulk of health workers today are not doctors and nurses but aides, orderlies, attendants, maintenance and kitchen workers. This has not always been the case.

From Little Acorns

The size and composition of the health labor force has shifted considerably over the last 70 years. It has constituted an ever-increasing share of the civilian labor force. At the turn of the century there were about 331,000 people in the various health occupations, comprising about 1 percent of the civilian labor force. (2) One-third of these were doctors, one-third nurses, attendants and midwives and the remaining third were veterinarians, pharmacists, dentists and lens makers and grinders. (The Census Bureau then included "healers and therapists" in its
count of doctors.) Except for the attendants, health workers were self-employed, offering the public treatments and cures of one sort or another. There were few health institutions, and these were reserved for the sick and dying poor with chronic or selected infectious disease. Medical care was disbursed in the home, barber shop, office or sideshow.

By 1930, at the beginning of the Great Depression, employment in health occupations had crept up to about 2 percent of the labor force. The distribution of health workers had changed radically from the beginning of the century. Doctors dropped from one-third to one-fifth of health workers, while dentists, veterinarians and chiropractors now made up about one-fourth. Nurses comprised the largest group of workers, but they had been split into two categories of about equal size—registered nurses, those licensed by the states, and unlicensed nursing personnel. During the decade of the Depression health employment increased from 815,106 to 879,962 at the same time that the total employed labor force was declining.

Today the health-care workforce is complex and highly stratified, including the highest-paid group of workers in the US and some of the lowest paid. In 1971, health services employed about 5 percent of the civilian labor force. Nursing personnel were the largest single group of health workers, about 2 million. There were about 750,000 registered nurses (RN's), 427,000 licensed practical or vocational nurses (LPN's) and about 800,000 aides, orderlies and attendants. Although the number of physicians tripled between 1900 and 1971, they today comprise only 7.5 percent of the health care labor force. {2, 5}

**Industrializing the Health Workforce**

In 1930 less than one-third of the health labor force worked in hospitals or other institutions. Today the proportion is nearly two-thirds. The growth of the institutional workforce began accelerating after the Second World War. In 1946 there were 830,000 hospital workers; now there are over 2.5 million. {2, 3}

Concomitant with the increase in the numbers of hospital workers has been the proliferation of job categories and professions. Greater New York Blue Cross, for example, recently sent a form to its member hospitals asking them to enter the number of people in different jobs. The form listed 280 titles, excluding physicians. A typical medium-sized general-care hospital with 300 beds employs 1,000 people. If the 280 job titles were equally distributed among this workforce, there would be fewer than four people in each category. Even with the technological complexity of modern medicine, one is hard put to imagine 280 different and distinct tasks to be performed. There is necessarily considerable overlap in the work done by different people with different titles, incomes and status.

Hospitals deliver a qualitatively different product from that of manufacturing plants. Nevertheless, their labor structures demonstrate parallels with that of other industries. Hospital administrators have their counterparts in plant management, maintaining the operation and assigning the workforce. Doctors as salaried employees of health institutions perform similarly to plant engineers in terms of their roles and responsibilities. Like engineers, doctors design the product and generally oversee the work process. Registered nurses, like shop foremen, supervise work at the point of production. Other nursing workers, directly providing patient care, are roughly comparable to skilled assembly-line workers. It is they who are responsible for the day-to-day creation of the product. Finally, the unskilled institutional maintenance people (housekeeping, food services and laundry) are not only drawn from the same labor pool as unskilled manufacturing workers, but do nearly interchangeable tasks.

This analogy between health care and manufacturing hides a critical distinction. Auto workers, for example, make cars, products of rather dubious social value. But health workers, often in spite of the organization of their workplace, deliver care. The content of their labor is considered by the rest of society to be worthy of the best of human endeavor.

As a service industry, hospitals contain a far greater percentage of highly trained workers than do typical manufacturing enterprises. But a large part of the hospital labor force is relatively unskilled. Clerical workers and institutional maintenance people account for nearly 40 percent of employees. Only 4 percent of the hospital workforce are physicians. There are about the same number of physicians as there are...
maintenance men in American hospitals. The greatest concentration of hospital workers is in nursing services. They run the gamut from skilled (RN's and LPN's) to semi-skilled (aides) to unskilled (orderlies and attendants). Of all hospital employees 43.5 percent are RN's (16.2 percent) or LPN's and LVN's (7.4 percent) or aides, orderlies and attendants (19.9 percent). The remainder of hospital workers are in clinical laboratory services (3.5 percent), clinical technology (3.2 percent), pharmacy (0.8 percent), administration (0.6 percent), dentistry (0.6 percent) and even smaller representations in other categories.

The Last Ten Years
Having created Blue Cross in the 1930's, hospitals assured themselves financial security and laid the foundations for industrial growth. After World War II, the growth of hospital laborpower was constant and steady. Incorporating a similar financing mechanism, Medicare and Medicaid have resulted in a growth rate that has been spectacular. The number of people employed in the health-care industry increased by more than 60 percent in the years 1965-71. (5,6) This is 30 times the rate of growth of the population as a whole and 15 times faster than the growth of the civilian labor force. (1)

Personnel costs have remained a constant percentage of hospital expenditures since 1965, about 60 percent. (3) Although such costs have been increasing, other costs have risen at the same rate. But net hospital income and net assets have increased far more rapidly. The total net assets of nonprofit general hospitals increased by slightly more than 90 percent between 1967 and 1973, compared with 79 percent during the seven years immediately before the implementation of Medicare and Medicaid. (3) Of the $13.5 million increase in hospital net assets $5.5 million was for new equipment. (3)
The introduction of new technology into most industries makes them less labor intensive; more product can be produced with fewer workers. The reverse has generally been the case with hospitals. New technology in hospitals has necessitated the training and hiring of additional workers to operate or monitor the machines, while at the same time a full complement of staff is needed to maintain existing services. As a result the fastest-growing health occupations during the last decade have been technological or support workers. For example, while the total workforce was increasing by 60 percent, the number of electrocardiograph technicians grew by 79 percent. (5)

Thus the last ten years have seen the acceleration of the manpower changes evidenced in earlier decades. Most notable about the recent period has been the enormous expansion in the numbers of people employed in the health-care industry. Secondly, there is increasing concentration in institutional settings. And this institutional labor force is becoming more and more fragmented and stratified into a multitude of professions and titles.

—Barbara Caress

Sterilization

Continued from page 6

cussion of sterilization begins with the clearly erroneous statement that "... sterilization is 100 percent effective. ..." As indicated above, ten women out of every thousand who undergo tubal ligation for sterilization will become pregnant. The book suggests, as does the Planned Parenthood booklet, that sterilizations and information regarding them are available from the Association for Voluntary Sterilization, a group confessedly more interested in population control than reproductive freedom.

Most importantly, there is no mention in the book of mortality or morbidity associated with sterilization. Paying some deference to the possible psychological implications of vasectomies for men, the writer suggests that men who are anxious about the effect of a vasectomy upon their sexual performance "... should not have vasectomies, because worrying about sexual performance is likely to impair a man's ability to have an erection, even though the production of sperm and male hormones continues." Women, however, receive less consideration. First, the authors include the testimony of one woman who experienced intense pre-operation fear of regret, but who subsequently was relieved "that she was free to proceed with her life."

There is no mention of the high rate of regret associated with sterilization, especially if the decision is made by a patient under 30, made during a time of stress, based on possibly temporary financial circumstances or initiated by the physician. In the last situation, a regret rate of 32 percent has been documented. (47) The importance of alerting women to this possibility is evidenced by a finding reported in the American Journal of Obstetrics and Gynecology that most of the women who regretted the sterilization became frigid (June, 1964).

Our Bodies, Ourselves compounds the error by suggesting as does the Planned Parenthood booklet, that a woman's sexual response is not lessened at all by sterilization but in fact "usually improves as soon as she no longer fears pregnancy." Finally, in stark contrast to the suggestion that a man who fears sterilization should not risk the possibility of altered sexual performance, women are told merely that they will "have to deal with their own deeply internalized feelings that someone who is infertile is inferior." This summary treatment of sterilization is especially regrettable in light of the 30 pages of the book devoted to an extensive discussion of almost every aspect of other contraceptive methods.

Medicine as Handmaiden of Public Policy

Doctors' attitudes toward sterilization and the misinformation about its impact stem from the same source: a clear-cut change in
government attitude toward population control. Though budget belt-tightening is today the byword for most government-financed health care, this is not the case for contraceptive services. On December 9, 1974, in implementation of amendments to the federal Medicaid law, HEW proposed to increase the federal contribution for birth control services provided to Medicaid recipients from 50 to 90 percent. And to further add to its expenditures, HEW intends to transfer family planning from optional to mandatory services, thus obliging every state to provide these services to every welfare woman. (49)

The government’s involvement with family planning has a long and checkered history. Fifty years ago, Margaret Sanger was jailed for demanding contraceptive services. Through most of the years that women fought for birth control and abortion, the government steadfastly opposed their efforts. (50)

Today, however, contraception has been embraced as a major ingredient of public policy. Open availability of birth control devices and accessibility of services is the result of two divergent perspectives. On the one hand, there are those who want birth control as a right and a matter of health, an important element in the demand by women for control of their bodies. But birth control is also an instrument of population control. For example, Dr. Curtis Wood, past President of the Association for Voluntary Sterilization, is an outspoken exponent of population control: “People pollute, and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians we have obligations to our individual patients, but we also have obligation to the society of which we are a part. The welfare mess, as it has been called, cries out for solutions, one of which is fertility control.” (51)

As befits his station, John D. Rockefeller III, Chairman of the President’s Commission on Population and the American Future, made the same point far more tactfully: “The Commission believes that slowing the rate of the population growth would ease the problems facing the American government in the years ahead. Demand for government services will be less than they would be otherwise, and resources available for the support of education, health and other government services would be greater.” (56)

Then President Nixon nominally rejected the Commission’s report because it called for the legalization of abortion. The facts, how-

"The welfare mess, as it has been called, cries out for solutions, one of which is fertility control."

Dr. Curtis Wood, past President Association for Voluntary Sterilization.

"...I have found that if the doctor does a proper job of offering sterilization to these women [on welfare], a high percentage of them would accept it. I have found that after three or four minutes of talking with them, they will accept it—they want the sex, but not the babies."

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Then President Nixon nominally rejected the Commission’s report because it called for the legalization of abortion. The facts, how-
ever, tell a very different story. Between 1967 and 1973 federal support for family planning services increased more than 1,300 percent, from $11 million to $149 million. (57) Dr. Louis Hellman, Assistant Secretary of HEW for Population Services, estimates total federal expenditures for family planning between 1970 and 1975 at $1 billion. (58)

Just as spectacular has been the growth of US spending for its birth control program abroad. The Agency for International Development (AID) increased its birth control program budget from $2.1 million in 1965 to $100 million in 1971. (59) In 1974 AID distributed 100 million birth control pills a month, paid for the insertion of innumerable IUD’s and provided the money and manpower for countless sterilizations. (60)

"It is better for all the world...if society can prevent those who are manifestly unfit from continuing their kind."

US Supreme Court Justice Oliver Wendell Holmes

In the government's own words, providing birth control services is population control. Replying to a United Nations questionnaire on population policy, it said the United States' policy was to actively provide the widest distribution of birth control services. "This position," the paper noted, "implies a policy de facto towards a further decrease in the rate of population growth." (61)

Lifting the parity formula and removing all formal impediments to sterilization, the American College of Obstetrics and Gynecology was bowing to the prevailing winds. Whether he knows it or not, the OB/GYN resident who said in defense of sterilization, "I just don't think it's good for them [welfare recipients] to drive around in a 1950 Chevy full of kids," was an agent of government policy. (62)

HEW's proposed changes in birth control services were capped off with a final twist, contained in the last paragraph. "Not included under this definition [of family planning services] are abortions performed either for therapeutic or non-therapeutic purposes." (63) HEW is happy to pay 90 percent of the costs of sterilization, but not abortion.

Compulsory sterilization of "incompetents" has long been a matter of law. Upholding a Virginia statute that allowed for the involuntary sterilization of an institutionalized person when the state determined that such a procedure was in the best interests of society, Supreme Court Justice Oliver Wendell Holmes wrote: "Experience has shown that heredity plays an important part in the transmission of insanity and imbecility... the Public Welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for those lesser sacrifices... It is better for all the world... if society can prevent those who are manifestly unfit from continuing their kind." (64)

The line between voluntary and involuntary sterilization is becoming thinner all the time.

-Barbara Caress (Much of the initial research for this article was carried out by Nikki Heidepriem, a third-year student at New York University Law School. The conclusions of course are those of the author.)

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The thesis of Juliet Mitchell’s controversial book, *Psychoanalysis and Feminism*, is that the oppression of women is not a function of a society dominated by men but is a result of a cultural process whose dominating figure is the father. History up to now has been the result of a law imposed upon male children by their fathers and the lack of such a law for female children. In making her arguments Mitchell relies heavily on Freud, accepting in the main his analysis of feminine masochism, passivity and limited superego development. Feminists must in her view accept Freud in order to make a cultural revolution that will overthrow patriarchy.

Radicals have criticized Mitchell for abandoning the social revolution in favor of the vague notion of cultural revolution. They regard her position as ahistorical, as portraying the family as an archetypal institution that does not undergo change. Feminists criticize Mitchell because her reliance on Freud seems to predicate the inferiority of women, which they would prefer to regard as a myth propagated by male chauvinists. The book has, in short, aroused a storm of negative criticism from the very community to which it is addressed.

The book is indeed ambitious. Mitchell wishes to redefine the problems of sexuality and to offer feminists a new theory and a new politics. A major portion of the book is therefore devoted to criticism of theorists who have been of consequence to the feminist movement, in particular Wilhelm Reich and R. D. Laing. In the process, Mitchell undermines present notions of what the feminist movement is all about. Further, she does so in a way that implicates much of radical politics—both those of the counterculture and those of a Marxist variety. Thus, it is not surprising that critics would rather pan the book than deal with its contributions.

In fairness, however, to Mitchell’s many critics, the book has many flaws, not all of which are defensible. One of the most important is the fact that, although the book claims to be a kind of synthesis of Marx and Freud, Mitchell apparently is ignorant of others who have worked on such a project, in particular those associated with the so-called Frankfurt school—Adorno, Horkheimer, Fromm, Marcuse and Habermas, among others. Her apparent ignorance of the work of this group lends her book a certain naiveté, especially with respect to Marx. She relies heavily on Engels rather than on Marx for an understanding of the Marxist social critique—a mistake that the Frankfurt school would never have made. (1)

Another problem with the book is that it is in some ways badly written. In the process of drawing together a number of complicated theoretical positions in order to focus on feminism, her prose emerges as a disconcerting admixture of technical and everyday language. Further, the structure of the book is awkward. Mitchell tries to place each of the
major figures she writes about into an historical context in order to show how his thought is related to his milieu. On the other hand, the level of her critique is so theoretical and abstract that the relationship between the thinker and the world about which he was thinking becomes irrelevant.

Having nothing to do with such defects, Mitchell’s book has to overcome resistance intrinsic to its subject. It tries to state a problem that, because it is difficult even to articulate in the modern context, escapes the reader who does not wish to listen. Mitchell is unwilling to see “femaleness” and “maleness” as either biological givens or as socially imposed distinctions. She sees the self, and its male or female attributes, as an identity formed by the child in his relations with others. The self is neither socially created nor given in nature but created in a separate sphere called culture. (2)

By utilizing Freud’s notions of the unconscious and of infantile sexuality, Mitchell believes that we can approach the “disreputable constructs whose value our emancipation from them contents of civilization” and the unconscious and of infantile sexuality are for Freud theoretical constructs whose value derives from their ability to account for the process of development of the infant from a bundle of drives to a self-directed human individual. Freud’s notion of the unconscious is that it is a structure and content of the mind of which we are generally oblivious but that affects our acts and our thoughts even if we are conscious of acting and thinking in a quite different way. The evidence for the existence of the unconscious comes from the analysis of errors, forgetting and ordinary dreams. The unconscious does not communicate to us directly but can only be known through a process of deciphering its activities. It has a story to tell but refuses to tell it directly; we only hear bits and pieces of the story in our dreams, in our repetitive activities and in our compulsions. The story it has to tell is that of our own process of self-formation, whose history is lost in our infantile past.

Infantile sexuality refers to the sensations of bodily pleasures and the losses of those pleasures on which our initial models of self are based: “... the ego is the precipitate of abandoned object cathexes and that it contains the history of these object-choices.” (4) Our conscious life emerges in accordance with the past, which we have hidden from ourselves but whose contents very often—unwittingly—make themselves known in the form of anxiety, guilt, and so on. What psychoanalysis has done is to provide modes of deciphering the activities of the unconscious in such a way as to enable us to gain control over our own life history.

According to Mitchell, Freud describes a differential process of the acquisition of culture in the male and the female. It is this description that feminists have objected to. It asserts that the process of self-formation assures a secondary place in culture for the female. Mitchell employs two models for presenting this differential creation of the self. The first describes the process from the outside, that is, as it would appear to an observer. The second model presents the same process from the inside, the child’s own model.

In the first model, Freud singles out the father as the central figure. It is not the nurturing activity of the mother, but rather the intrusion of the father into the mother-child relationship that makes possible the transition from animal functioning to cultural being. The mother-child relationship is, as such, an animal relationship. It is the appearance of the father and his insistence that the relationship be broken that destroys that relationship and makes possible a new relationship in which the child experiences himself as a separate entity.

The breaking of the mother-child relationship means something quite different for the male from what it means for the female child. For the male child the paradigm is the Oedipus complex, in which the original attachment to the mother must be replaced with an identification with the father in such a way that the desire “to have” (and to be part of) the mother is transformed into the desire “to be like” the father. The original love object of the boy is not altered, but the realization of the original attachment is deferred to a future time, when the boy shall be as “big” as his father—literally and symbolically.

For the female child, how-
ever, the process is considerably different. Here the initial attachment is also to the mother. The first task which the child must accomplish is to shift that attachment onto the father. It is only secondarily that the child must inhibit her desire for the father and effect an identification with the mother. This second requirement is not so strongly demanded precisely because of the incomplete abandonment of the desire for the mother. Consequently, the female child never develops the strong identification and internalized inhibition that leads to the erection of the superego in the boy and consequently his ability to sublimate his desires into work and other forms of cultural activity.

The second model of the child's transformation attempts to show how the breaking of the mother-child relationship occurs from within the child's experience. It is within this model that the constructs of the "castration complex" and "penis envy" are located. For Freud these are technical terms for describing the means that the child employs to accomplish the above-described transformations.

In Freud's scheme of things the bisexuality of the infant is a necessary construct. The process of acquiring sexual identity has little or nothing to do with either anatomical distinctions, biological urges or socially imposed roles. Masculinity and femininity are "mental ideas," to use Freud's language, which have all the more power because they are unconscious. As mental ideas they describe without our awareness, the stages we have gone through and the wounds we have received in becoming male and female.

In the view of the child, the penis and the clitoris are identical objects of auto-erotic satisfaction. As such they are the anatomical referent for a very particular kind of anxiety. The form of this anxiety in the boy is fear of castration, the loss of the object of satisfaction. It is a fear that inspires his desire "to be like" his father and "to be recognized" by him, whose most important result is his negation of his desire "to have" his mother. This moment of negation is at the same time the establishment of his father's demands within himself as the model of his own self-demands (the superego) and the overcoming of the Oedipus complex.

For the girl, however, the insignificance of the clitoris, not
as an object providing pleasure but in comparison to the externality of the boy's penis gives rise to the recognition of her lack and the wounding of her vanity, which is similar to the wounding the boy receives in his attempt to compete with his father. This lack, which the girl perceives as characteristic of her mother as well, leads to the girl's hatred and contempt for the mother. She shifts her desire "to have" onto her father and develops an incomplete desire "to be like" her mother. The resolution of the shift in desire as well as the identification with the mother is always incomplete. The incest taboo—which the boy comes to recognize and which thereafter constitutes his process of self-regulation—never fully takes place for the girl. She still wants "to be like" her father and "to have" the original object—the mother. Her recognition that she cannot consist in "not being able," and thus the love of the father remains a kind of substitute gratification. The desire "to have" remains primary but is altered into the desire to have a baby, particularly a boy, which will be a replacement for the longed-for penis. Whatever resolution does occur is accompanied by the shift away from the clitoris as a source of pleasure onto the vagina. Naturally, and Mitchell does not imply otherwise, the paradigms outlined above may and do have other resolutions in a variety of permutations and combinations.

In this second model of differential formation the phallus plays a major role. Symbolically it is the object around which the infant makes the distinctions of difference and sameness, upon whose grounds identification (self-modeling) takes place. The social relationships between parents and children, while they set the stage for the inter-subjective drama, are relatively indifferent to the archetypal establishment of culture itself. Here the father is the symbolic father, or more accurately the phallus. His power rests in the negation or wounding of desire, which is in a sense turned back upon itself and which becomes the child's desire not for unification with the source of pleasure but for the pleasure of being recognized by another who is not oneself. It is this which transforms the child into the human child. It is the phallus that represents patriarchal culture, and that fact makes it more than the father's penis or the father's social power. Patriarchal culture is no mere ideological form of experience but—up to now—the condition under which all culture becomes possible. The phallus is the negation of the mother-child dyad and hence the law of an otherwise lawless and solipsistic infantile universe.

Having stated her view that the problems for feminism derive from the peculiar cultural constitution of human beings, Mitchell looks at two thinkers who have been of importance to radical, particularly counterculture, movements. Both Wilhelm Reich and R. D. Laing have offered descriptions of our cultural experience that have impressed many of us who feel alienated in and dissatisfied with our society. In fact, Mitchell chooses to look critically at these thinkers precisely because their descriptions of the functions of social institutions, especially the family, have had so much power. Indeed, she finds their descriptions much more interesting than those that have emerged from the established psychoanalytic community.

Mitchell makes her critique of Reich and Laing by adopting the Freudian position dogmatically. (5) She asks what is lost if one neglects such concepts as the unconscious and infantile sexuality. Her answer is that a good bit of analytical power is lost. She shows that despite the acuity of their sociological descriptions, both Reich and Laing fail to tell us why society is as it is. Rather, when they try to provide an explanation, they produce mystifications—a kind of secular religion, or ideology. In substance her argument is that both Reich and Laing ultimately restate in a 20th-Century version what Durkheim once called the religion of the individual—the modern belief in the absolute datum of the individual and his "experience."

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**Patriarchal culture is no mere ideological form of experience but—up to now—the condition under which culture becomes possible.**

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**Reich: The Ideology of Sex Economy**

To Mitchell's credit, she attempts to take on the whole of Reich's broken corpus. The positions he takes as the radical activist of sexual politics and the quietist high priest of orgonomy are in her view coherent. The prime target of crit-
icism is Reich's reduction of the unconscious to a biological construct whose literal content is sexual (instinctual) energy. This leads to a kind of naive Rousseauianism in which the biologically pure individual is imprisoned in his sociological relationships.

The individual's task is one of freeing himself from this fall into the world of alienated being through the release of his repressed sexual energies. The corollary of Reich's rejection of the unconscious as one's own repressed and therefore alienated history is the rejection of infantile sexuality, by which and through which this history is formed and given a language. The consequence of these two rejections is pansexualism: "Free sexual expression became the highest good; and naturally it followed from this that the child's sexual impulses were not only not to be discouraged but, on the contrary, fostered and satisfied—the meaning of 'infantile sexuality' becomes entirely and simply social. A libertarian society can provide the answer. The larger question of the acquisition of the human order, the transmission of the most residual demands of the general culture is excluded."

Despite Reich's effort to unite Freud and Marx in a descriptive sex-economy, Mitchell argues that he has misunderstood both of them. The underlying difficulty is Reich's notion of dialectics. Although we cannot go into this difficulty here—and in fact Mitchell gives it rather short shrift—the point is that Reich sees dialectics as a falsifying differentiation of nature out of a pre-established harmony and unity. A first and necessarily "false" differentiation is the sexual one upon which all other social differentiation is ultimately based.

"Reich's theory is that patriarchy is the sexual suppression of children, upon which the economic and political functions of the family are carried out. Patrarchy, and capitalism as one of its agents, "inaugurates" the necessity of compulsive marriage, which involves sexual suppression which, in turn, becomes a personal struggle against one's own sexuality." (7) The modern "authoritarian family" reproduces the conditions under which political as opposed to economic domination is expressed. The family is seen as the social institution where the demands and requirements of the social order are provided for by the functional equivalent of the authoritarian state—Father as Führer. Sexual repression hatched in the family to serve the demands of the social order must be liberated. "Both psychoanalysis and Marxism are reduced to the sociology of the family and as the family as a social institution is found to be at fault, natural biology can be made to triumph against social evils." (8)

Reich's ultimate proposal is, nonetheless, we are preparing for a new stage of phylogenesis that resides in a "universal vaginal orgonatic functioning." This means an obliteration of the socially imposed distinction male-female and a return to a unity whose overtones are religious. He offers a religious reconciliation in which good and evil, male and female, are a differentiation out of the all-being whose name is Woman.

Mitchell draws two conclusions from her examination of Reich. First, to neglect the problems of an unconscious mental life for those of biology is paradoxically to be locked into an analysis of the social institution of the family. The Oedipus complex thus becomes a description of the social relationships within the family. Different family structures must produce different results. So far as women are concerned, however, this has not been true, as witness, for example, the ubiquity of cultural conceptions of the woman as passive, as representing the profane as opposed to the sacred, and so on. (9)

Secondly, Reich's conception is imprisoning in some what the same sense as neurosis is. Just as in neurosis one is compelled to repeat in phantasy the conflicts of one's past mental life, whose appropriateness to a real present is highly dubious, so Reich, lacking the tools for deciphering the unconscious, is obliged to repeat the cultural phantasies of the past in his own work. The return to an undifferentiated oneness with the all is perhaps a satisfying expression of the uninhibited sexuality of the infant, but it is not an adequate theory to account for cultural change. This is reminiscent of religious constructions of past eras in which the future was a return to a lost paradise. It is this form of reconciliation of the experience of an alienated existence, a reconciliation at the level of speculative thought, which Mitchell calls ideology.

Laing: Knots and More Knots

Laing has no room in his theory for either a concept of an unconscious or of infantile sexuality, largely because he has eliminated the idea of a subject who creates meanings.
Laing is interested in "persons," by which he means the network of relationships in which an individual is involved. The key categories of his analysis are behavior and perception. Distortions occur not in individual subjects but in relationships, when the behavior of one member is misperceived by the other. Because A misperceives the behavior of B, he defines B through his misperception. B is thus defined not as what he is but as what A misperceives him to be. B then reacts to A's behavior toward him, which is not what B understands himself to be, and so on.

In this way the distinction "sane" and "mad" is produced as the relationships between persons grow more and more distorted. It is interesting in this context to note that Laing's book *Sanity, Madness and the Family*, Volume I, on the schizophrenic family, which was supposed to be followed by Volume 2, on the non-schizophrenic family, has been re-issued without the volume number; the work on non-schizophrenic families never took place. Presumably Laing no longer could find a family he considered non-schizophrenic. Given his categories and the possibilities for distorted interrelations, this is not hard to believe. Mitchell argues quite convincingly that Laing, because he concerns himself with "behavior" and not with "meaning" is ultimately reduced to demonstrating over and over the mundane observation that behavior and perception are not congruent.

Mitchell's point here is quite clear. Because Laing sees the individual only as a conscious subject, the location of distorting and distorted processes of self-understanding must be functions of the content of his conscious perceptions (misperceptions). Since for Laing the subject only exists on the conscious level, his lack of self-understanding must then be a function of other people's distorted perception of his behavior as it reflected back to him as in a mirror. Thus any definition of the person's behavior that is not equivalent to his self-understanding is an alienation of his behavior.

While this leads to Laing's political radicalism, in that many of the categories of our social experience limit and define us in ways that are antithetical to our self-understanding, it also leads in the direction of his mysticism. It is the voyage within self that can return us to the wholeness from which we have been separated by the "egoic" functions of role playing and false self-definition (i.e., that dependent on the misperceptions of our behavior by others.)

Mitchell defines Laing's movement toward mysticism as having been implicit in his work from the first: "In the early work, the schizophrenic's 'madness' is found to be an intelligible response to certain mad-making social pressures; in the middle work the mad-making social pressures come to seem the real madness; by default, the schizophrenic's response has moved from being intelligible to being 'normal'; in the late works the schizophrenic's madness has become the true sanity from which the vast majority of people are divorced. Many critics
have decried Laing’s descent/ascent into mysticism, but it is clearly the logical process of his preoccupations.” (10)

By defining the person only at the level of consciousness, Laing can only reproduce the contents of consciousness—the conflict between self and other, between my perception of behavior and the other’s perceptions of my behavior. As an important example of what is missed in such a perspective, Mitchell offers the following: In his case studies of “schizophrenics,” Laing (by chance) offers only those of women. All the portraits of these women center around the mother-child relationship. The father is conspicuous by his absence. In Freud’s view, the problem of psychosis emerges precisely from this “pre-Oedipal” world of mother and child in which the child’s “self” has not yet been formed. Since Freud’s analysis of both female psychology and psychosis located this mother-child relationship as crucial, Mitchell finds it important that Laing does not even notice the absence of the father. She shows in this that while his own studies give evidence of the validity of the Freudian view, Laing does not even acknowledge the problem: “...in leaving out the father, he [Laing] is omitting to give any significance to the patriarchal law and order in which all our families are placed. The importance of the patriarchal law is as absent from his accounts as it is from the pre-Oedipal phase within which psychosis develops—his ‘science’ is thus, like ideology, purely reflective, a mirror-image of the predicament.” (11)

In Mitchell’s view, Laing, like Reich, becomes an ideologist. Beginning with a sociological definition of the person, Laing eliminates the notion of an unconscious and consequently of a past that informs the person’s current actions without his conscious knowledge. All events take place in an eternal present of social relationships that cannot be elucidated beyond the level of A misperceiving B and B misperceiving A and so on and on. The reconciliation of this situation of alienation is a mystical journey into oneself in which all alienation is eliminated.

If we adopt the positions of Reich and Laing, the problems of female oppression arise out of social institutions, particularly the family. In Reich’s view this is a result of the sexual oppression of children produced by the demands of an authoritarian political structure. Laing, on the other hand, sees the family as defining the child out of his “natural” humanity. The task which emerges from this analysis is the transformation of social institutions, particularly the family. The demands which follow from this analysis include social justice for women, equal opportunities in the workplace, the establishment of a matriarchal society, new forms for the socialization of children and, in its most dramatic form, the demand to eliminate the family.

Untying the Knot

While Mitchell does not deny that the family, and the consequent roles demanded of the female, are oppressive, she feels that the problem is not simply that of a male-dominated society, although that is a symptom of the problem. The real problem, as she understands it, is created from the differential ways in which culture is acquired by men and women. It is the role of the father in the institution of self that must be examined, criticized and overcome. The problem stated in this way is a problem of a father-dominated culture.

It is this assertion of the centrality of patriarchal culture that leads to what appears to be a major contradiction in Mitchell’s book, a contradiction that has given her critics more than sufficient ammunition for a rejection of her work. If it is true, as she claims, that the father represents in the child’s mental life a necessary image of law by means of which culture becomes possible, and if culture is acquired differentially by males and females, then how is it possible to introduce any change? Are we not left with a situation that, like fate, can be ameliorated but not altered? Are we not all simply stuck with the Father as a symbol of the wounds of culture’s violent origins?

Mitchell’s answer to this criticism is complex and deserves our attention. Whether she actually overcomes the criticism remains to be seen. What she tries to show is that what was once necessary as a precondition of human culture has ceased to be necessary. In making this argument she first describes the patriarchal origins of civilization, using the work of Claude Lévi-Strauss to bolster the Freudian myth of the patriarchal origins of culture.

The Freudian myth, as presented in Totem and Taboo as elsewhere, is used by Freud to support his claim that “ontogeny repeats phylogeny.” That is, Freud—and Mitchell follows him in this—holds that what is necessary to account for hu-
man culture is the assumption that the life history of the individual and the life history of the species is the same history. Freud argues that in order to have culture, one must have law—a form of order that when internalized, regularizes human relationships. How was it possible for our humanoid ancestors to inhibit their desires in such a way to accept law? Freud’s answer to this is the following myth.

In the beginning the father, because he is the strongest, monopolizes all the women in the group. His sons hate and envy his privileges. They take their revenge upon him by killing him. Having done so, they feel remorse because they loved as well as hated the father. They make a pact renouncing further monopolistic relations with mothers and sisters and sign it by eating morsels of the father’s flesh. The father’s actual prohibition of the son’s relations with their mothers and sisters becomes an internalized mental inhibition, which is the first law. The accomplishment of this internal denial is recapitulated, in Freud’s view, in the Oedipus complex of every male child. The claim of truth that Freud makes for this myth is not that it happened just this way but that some internalized prohibition is necessary for the transition from natural to cultural being.

The transition from nature to culture is also a primary concern of Lévi-Strauss. (12) He argues that in all known societies the problem of this transformation is a problem of exchange and that the first and most important exchange is that of sexual objects. As it turns out, however, in all known societies men have exchanged women, rather than women exchanging men. The motive Lévi-Strauss assigns to exchange is that it is the act that establishes a human relationship. What this means is that the situation is not one of barter, where an object is exchanged for an object, but rather that the object is a mediator of an exchange of purely human goods—prestige, respect, recognition. The exchanged object, as such, serves to establish the relationship between individuals who otherwise are not related; it brings into existence not an instrumental relationship in which need serves need, but a reciprocal relationship in which the desire of the one for recognition is met by a response by the other and so on. Lévi-Strauss argues that the precondition for such exchange is an establishment of differences. In the all-important case where groups of brothers exchange their sisters, the crucial differentiations are “my sister” (mother) and “not my sister” (mother). “My sister” is a forbidden object (the incest taboo) which the sisters of others are not and are therefore possible objects of desire for men.

Mitchell believes that the Freudian myth accounts for the initial inhibition that distinguishes among women and thereby establishes the pre-
conditions for exchange and thus inaugurates the network of kinship relations, both as a system of interactions and a system of production. Lévi-Strauss’ account of the origins of culture, like Freud’s, demands an internalized prohibition that must be generated in men but need not be generated in women. This for Mitchell is the nature of patriarchal culture.

Mitchell claims that while such demands and such a differential may have been necessary. In fact, if we look at our civilization, we know three things: First, exchange and production are no longer dependent on kinship or organization. Second, as kinship becomes a negligible factor in the condition of production and exchange, the family’s sentimental value increases and the demand that it be recognized as “natural” and “vital” increases. Third, as the family draws together as a sentimental unit, it increases the temptations that the incest taboo prohibits, and the demand for renunciation takes higher and higher tolls on the individual in the form of neurosis and psychosis.

From these observations, Mitchell argues that the establishment of minimal differentiations via the kinship system and the consequent demand that women function within that system are no longer necessary. The exchanges and interrelationships are established in a system of production which is social in the broadest sense, that it is no longer a system imposed upon man by his needs for subsistence but one that is freely created by him.

Secondly, it follows that the family no longer provides the setting in which necessary differentiations are created. Rather the nuclear, “biological” family plays a role in modern society as an ideological force which perpetuates an outmoded form of cultural existence. This suggests that the problem of the woman’s movement is the critique of the ideology of patriarchal culture as the first step toward a genuine overcoming of patriarchal culture. The problem must be made conscious in order that its implications can be dealt with.

It is in this context that Mitchell has suggested that the feminist cultural revolution must be made along with a socialist revolution. The nuclear family, she says, has persisted in socialist societies because its modus operandi springs from different sources than those of the economy. The task of the socialist revolution is a task of transforming the social relationships of production. The task of the cultural revolution is that of transforming cultural conditions of exchange. The patriarchal establishment of cultural exchange was once necessary to the system of production. It no longer is. Now the social system of production has made possible the establishment of new forms of cultural exchange. It must be understood as such in order for a new form of action to emerge to change current reality.

This is all very well at the level of theory, although—and I think her Marxist critics are right in this—Mitchell’s separation of a cultural from a social revolution seems to reflect her limited understanding of Marx’s notion of a social revolution. What she seems to mean by a socialist revolution is what many people would call state capitalism. Particularly for those of us who would say that there has been no revolution as Marx anticipated it, this particular division of things does not make much sense.

At first sight, Mitchell’s notion of a new praxis for feminism does not make much sense either. Actually, she does not recommend a new praxis at all. She merely points to certain practices that developed in London during World War II—integration of women into the work force, extension of compulsory education, establishment of preschool programs, distribution of food and other necessities through communal restaurants and so on. One might well ask, does it make sense to talk about overcoming mankind’s universal experience of patriarchy by establishing more day-care centers and by creating wage-slaves of women? One’s first response is, “You must be kidding!”

One could hazard a guess as to what Mitchell has in mind here, but she does not really tell us. She might mean that rather than the break-up of the family in Reichenian terms, she envisions the extension of the family into non-patriarchal forms. Such a cultural family would not be defined with reference to biology but with reference to the social system of production. In other words, there would still be so-
ocial entities that provide children with models for identification, with images of self in accordance with which they can transform themselves but these models need not be male or female in the usual sense. The nurturer can be a male as well as a female. The figure who breaks the dyadic nurturing relationship can be a woman as well as a man. The child's task of self-formation can and should take place outside the family described by the female's nurturing role and the male's role as the negation of that nurturing relationship. Be that as it may, Mitchell does not really deal with this problem in anything like the depth it deserves.

On the other hand, perhaps the fact that Mitchell hasn't any remedies should not disturb us too much. She has offered us a critique of ideology that in the long run might be more useful than an unreflective program of action. Mitchell's critique of Reich and Laing is reminiscent of an old debate in which Marx engaged with the "Left Hegelians" of his day, who believed that one made revolutions simply by changing one's consciousness of reality. The reconciliations of the contradictions of reality could be righted theoretically. This is what Laing and Reich do. They describe the contradictions of reality, but they resolve them by theoretically abolishing them. As Mitchell powerfully shows, those who attempt merely to describe reality end up caught in the reality that they describe; they are reduced to resolving the contradictions they see in speculative thought.

Mitchell shows that the power of a Freudian analysis comes from the constructs of the unconscious and of infantile sexuality. It is through these constructs that cultural reality can be seen not as it is given but in the process of its construction. An analogy that may elucidate this point is Freud's notion of the role of an external or a somatic stimulus in the construction of a dream. Freud says that indeed a bell or a belly-ache can stimulate a dream, but it cannot account for the dream that is created; otherwise all dreams caused by the same stimulus would be the same. A reductive analysis of a dream holds that its explanation is the stimulus. Freud claims that the stimulus itself is assimilated to a world of meanings that refer to matters quite different from ringing bells or aching stomachs. This world of meanings can be interpreted only in the framework of the dream itself. The stimulus acquires its meaning from a context whose contents is the distorted and fragmented wishes of one's past infantile history. Culture is similarly constructed in accordance with demands that cannot be reduced either to biological needs or to sociological functions. What the notion of the unconscious does, in an analytic framework, is to provide a method for reconstructing the contradictions and tensions of the process of acquiring our present identity and for describing the emergence of the self.

I do not think that Mitchell herself uses these constructs to make a cultural analysis. What she does provide is an understanding of what tools are there. Particularly, she shows that there are tools the use of which could provide a new analysis of the problems of feminism and the family context out of which they emerge.

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References
1. In the 1930's the Frankfurt school was concerned with the family. The largely untranslated Studien über Autorität und Familie is only one example. Those interested in the Marx Freud synthesis of this school might examine the essay "Authority and the Family" in Max Horkheimer's Critical Theory (Herder and Herder, 1972). Other relevant works of this school are Herbert Marcuse, Eros and Civilization, Jürgen Habermas, Knowledge and Human Interests (especially the chapter on Freud), and Erich Fromm, Escape from Freedom.
2. Mitchell adopts the position of the French psychoanalyst Jacques Lacan for her understanding of Freud. Lacan emphasizes that part of the Freudian view that makes the problem of the intersubjective creation of the self central. Lacan's notion of the self is first of all a self reflected as in a mirror. In the mother's face as she reacts to the child's needs and demands. It is only through this alienated image of self that the child can create an image of self. The perceptive reader will see that this is the basic assumption of Mitchell's criticism of Reich and Laing. While they hold that all objectifications of the self are alienation, Lacan believes that it only through such "alienations" that the self becomes possible. The best introduction to Lacan is Anthony Wilden (ed. and trans.), The Language of Sex. (Johns Hopkins, 1968).
3. Mitchell makes the argument several times in her book that she is only through such "alienations" that the self becomes possible. The best introduction to Lacan is Anthony Wilden (ed. and trans.), The Language of Sex. (Johns Hopkins, 1968).
5. There is as one critic has noted a theological structure to Mitchell's argument here. She adopts Freud's position uncritically in order to see how others, by diverging from it, have made errors. This criticism is essentially correct, but the proof of the pudding is in the eating. As I have tried to show, I think something valid comes of this procedure.
7. Ibid., p. 211.
8. Ibid., p. 215.
9. These are my examples of types of "the female" that one can find in the most casual perusal of the anthropological literature.
11. Ibid., p. 291.
12. The work of Claude Levi-Strauss has been the subject of a good bit of radical criticism. This then becomes a basis from which to attack Mitchell. However, much of the criticism of Levi-Strauss has been of the implications he draws from his analysis—a static conception of man's nature and an ahistorical bias. One need not throw out his babies along with their bath water. I do not think Mitchell's dependence on Levi-Strauss' analysis means her adoption of his philosophical positions. Levi-Strauss' most accessible work is Tristes Tropeziers, although it does not bear directly on problems discussed by Mitchell. One might also look at his collection of essays entitled Structural Anthropology.
FACTS AND FIGURES
Preliminary figures on health expenditures for Fiscal Year 1974 are now available. Highlights reported in HEW’s Research and Statistics Notes, November 29, 1974, include:

- US health spending reached $104.2 billion, up from $94.2 billion in fiscal 1973. This amounted to a per-capita expenditure of $485, up from $442 last year.
- Total spending increased 10.6 percent over fiscal 1973, slightly more than the increase in 1973, when wage and price controls were in effect for the industry.
- Despite these increases, health expenditures remained at the 1973 proportion of GNP—7.7 percent.
- Public spending on health increased at twice the rate of private spending, due mainly to substantial increases in Medicare and Medicaid expenditures.
- The largest expenditure category continues to be hospital care, accounting for 39 percent of total spending.

The full report and analysis of the previous year’s health expenditures generally appears in the February issue of the Social Security Bulletin.

FORD REVERSES GEAR
President Ford recently released a proposal for cutbacks amounting to $2.5 billion in the Department of Health, Education and Welfare’s budget for fiscal 1975. This would include $276 million in health programs, $882 million in Medicare and $368 million in Medicaid. Among health programs, Hill-Burton hospital construction funds and National Institutes of Health grants would be hit hardest. Medicare beneficiaries under Ford’s proposal would be asked to pay 10 percent of the cost of hospitalization under Part A, and to pay an increased deductible of $67 a year for physicians’ services under Part B. A maximum for out-of-pocket costs under each program would be set at $750 a year. The Administration proposes to reduce the federal share of Medicaid expenditures from 50 percent to 40 percent. Most of these cuts will require congressional action. They come on top of substantial budget cuts made by Congress in HMO and PSRO funds in the recently passed HEW appropriations bill, as well as a number of cuts made through regulatory and administrative actions. There are rumors that the President’s Fiscal Year 1976 budget will embody even more drastic cuts. (Washington Report on Medicine and Health, December 2, 1974.)

SICK PATIENTS, HEALTHY INTEREST
The sale of tax-exempt revenue bonds for private hospital construction is becoming big business, reports the November 13 New York Post. Sales reached $583 million in the first six months of 1974 and were expected to reach $2 billion by the end of the year in the 27 states where such bonds are now permitted, according to Robert McCormick, investment banker for Dillon Reade and Company. Recent bonds have had a return rate of 8 percent.

Hospitals are turning to tax-exempt bonds as an alternative to bank loans and private financing as construction costs skyrocket, and investors are turning to them as they realize
the security as well as rate of return on the investment. "Statistically, there are very few defaults on hospital obligations. Hospitals are seen as a good risk, since people get sick regardless of the economy," said McCormick. More pertinent is the fact that 90 percent of hospital bills are paid by third-party insurers, so that "the risk is underwritten and insured to a large degree," and that "the trend toward a national health insurance program adds further backing to hospital bond ownership."

SICK PATIENTS,
HEALTHY TAX DODGE

Finally, if profits aren't your main worry, but taxes are, there is the Howard Hughes style of health system investment. Jack Anderson (December 19, 1974) reports that the phantom billionaire has managed to pay no federal taxes whatsoever throughout most of the last decade (except for one year when he reportedly got stuck with a $7 million tab). Apparently one of his chief tax-saving devices was giving money to the Howard Hughes Medical Institute.

SICK PATIENTS,
HEALTHY PROFITS

If bonds aren't your bag, however, there are more ways than one to make profits on the health system, even during these recession-ridden days. For example, Hospital Affiliates, Inc., a hospital management firm, has announced an 18 percent increase in earnings per share for the quarter ending September 30, 1974, the 18th consecutive quarter in which it has achieved a substantial increase in earnings per share, according to the Washington Report on Medicine and Health (November 11, 1974).

Then there is Community Psychiatric Centers, Inc., a largely California-based chain of acute-care psychiatric hospitals, which is "headed for its sixth consecutive year of record profits," according to Barrons (December 23, 1974). Profits per share were up 19 percent for the year ending November 30, 1974 compared with the previous year. Barrons reports that 85 percent of the company's billings come from private insurance, less than 10 percent from Medicare and the rest from Medicaid.

SAVED IN THE NICK OF TIME

It appears that recent struggles to keep Public Health Service hospitals open have resulted in victory. In an unexpected policy reversal, the federal government announced on December 15 that it plans to revitalize the network of nine hospitals and 26 clinics that now serve primarily merchant seamen, Coast Guardsmen, Indians and federal prisoners. Dr. Edward Hinman, new director of the system, has announced an expanded program for the hospitals, including community patient care, alcoholism and drug abuse research, day care for the disabled, rehabilitation, preventive dental care and health screening for poor children.

HOSPITAL HAZARDS

The National Institute for Occupational Safety and Health (NIOSH) is now conducting its first study on work hazards in hospitals. Its initial report concludes that "the safety record of hospitals is inferior to that of many industries that send accident victims to these facilities."

The report goes on to show that "during 1958 through 1970, the injury frequency rate for medical and other health services increased 14.8 percent. State hospitals showed an injury frequency rate of 21.4 [per million employee hours] by 1970, far in excess of the 13.2 rate of manufacturing industries for the same year." (NIOSH, Hospital Occupational Health Services Study, Environmental Health and Safety Control, July, 1974, p. 1, HEW Publication No. (NIOSH) 75-101.)

LABOR DEPARTMENT TURNS A DEAF EAR

The US Labor Department recently surprised its supporters—nothing surprises its growing ranks of critics—by announcing its intention to maintain the present 90 decibel standard for industrial noise exposure. This came after both the Environmental Protection Agency (EPA) and the National Institute for Occupational Safety and Health (NIOSH) recommended lowering the standard to 85 decibels. NIOSH had even conducted its own study, which showed evidence of hearing impairment among 49 percent of all workers age 55 to 70 years who were exposed to 90 decibels for 20 years or more. An economic feasibility study commissioned by the Labor Department, the kind of study that in the past had been used by the Department to justify inaction, concluded that 1.68 million workers will be handicapped if present noise exposure levels continue, but that 1.47 million will escape hearing impairment if the standard is lowered to 85 decibels. The Labor Department decision is being challenged by the EPA, which...
says it will attempt to appeal it to the President's Council on Environmental Quality, if necessary.

The Labor Department decision was announced by the Assistant Secretary for Occupational Safety and Health, John Stender, who suffers a hearing disability from working for many years as a boiler-maker.

**MEET THE AMERICAN MORALITY ASSOCIATION**

Alas, the AMA has fallen short of the tide of social progress once more. Delegates to its annual clinical session failed to endorse the removal of criminal penalties against consenting adults, other than married couples, who engage in sexual behavior, as recommended by the AMA Board of Trustees. The reason? The delegates feared that this recommendation would be interpreted as an endorsement of prostitution.

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