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Double Indemnity

Buried in the back pages of the mammoth Sunday New York Times on April 22, 1979, was the report of the findings of the general counsel of the Department of Health, Education, and Welfare that its numerous civil rights and affirmative action programs for minorities were “almost entirely unaffected” by the Supreme Court decision in the infamous Bakke v. Regents of the University of California. During the entire year before the June 1978 decision, Bakke dominated the headlines and covers of influential publications such as Saturday Review, The Atlantic and the New York Times Magazine. (For the Health/PAC assessment, see Bulletin No. 76, May/June 1977, and its
special report, 'The Myth of Reverse Discrimination: Declining Minority Enrollment in New York City's Medical Schools' by Barbara Caress.) The Court’s decision—straddling more positions than nine acrobats—found Allan Bakke entitled to a seat at the medical school of University of California-Davis because the school’s special admission process for disadvantaged applicants violated Title VI of the Civil Rights Act of 1964. But, the Court said, consideration of race among other factors was permissible in the admissions process.

When HEW's general counsel finds almost nothing affected by Bakke, the message is clear: either affirmative action has already been undermined to such an extent that Bakke could do no further harm, or the Bakke decision was more important as a media event than it was as law. For the health professions both are true. The anti-affirmative action backlash combined with the forces of inflation, changes in federal health manpower and financial aid policy, and institutionalized myths and racism have broken and turned the momentum of affirmative action as well as the opportunity and rationale for the health professions to suspend their largely inequitable and ambivalent efforts at minority recruitment. This year the percentage of minorities newly entering health professional schools has regressed to levels of ten years ago when pressures for affirmative action were just beginning. Moreover, a comparable limit upon women entering the health professions can also be seen on the horizon (1).

The intent of this article is to examine these forces, developments and policy changes which are closing a door that was all too briefly and cautiously opened.

A Brief History of Affirmative Action

Affirmative action is rooted in political and social movements, beginning with FDR's creation of the Fair Employment Practices Commission in 1941, following a threatened march on Washington by A. Phillip Randolph and other Black leaders. The presidential directive ordered an end to racial discrimination in federal hiring, with the Fair Employment Commission empowered to investigate compliance with the order.

During the mid-1960's, in response to later civil rights demonstrations and a renascent civil rights movement, President Lyndon Johnson extended equal employment coverage through Executive Orders 11246 and 11375. These Orders prohibit discrimination in employment by all employers holding federal contracts, and require affirmative action programs by all government contractors and sub-contractors receiving contracts of more than $50,000 and employing more than 50 persons. Title VI of the Civil Rights Act of 1964 forbids discrimination against students on the basis of race, color or national origin. Title VII of the Act, as amended by the Equal Employment Opportunity Act of 1972, forbids employment discrimination on the basis of race, color, national origin, religion or sex by any employer of fifteen or more persons, public or private, whether or not they receive federal funds.

The first federal sex discrimination legislation, the Equal Pay Act of 1963, was also enacted in response to the civil rights movement. It requires equal pay for equal work regardless of sex. In 1972 this was extended to cover executive and professional employees, including college and university faculty.

Compliance with federal civil rights orders and statutes has been undermined by inconsistent and confused regulations issued by the bureaucracies involved and by numerous, contradictory court orders. Considerable interagency conflict between the Departments of Labor, Justice, and HEW and the Equal Employment Opportunity Commission have further diluted the responsibility for monitoring and enforcing anti-discrimination guidelines. Only in September 1978 did these agencies publish uniform guidelines for employee selection procedures. Their underlying principle is that any test or other selection procedure which has an adverse impact on minorities or women is illegal unless test performance can be clearly shown to predict job performance. Where statistical evidence of on-going employment discrimination exists, institutions are only asked to document that good faith has gone into the effort to recruit women and minorities, not necessarily that progress has been made toward integration.

The pertinence of these legal mandates for the health professions is profound, given their historical discrimination against minorities and women. As recently as 1963, five American medical schools were still officially closed to Blacks (2). Not until 1964 did the American Medical Association vote to prohibit racially discriminatory membership policies (3). UCLA did not graduate its first Black physician until 1970 or accept its first Black dental student until 1974 (4). As recently as 1965 the National Dental Association claimed that in eleven southern state organizations the American Dental Association “only rarely accepted Negro members” (5). Full, open membership did not arrive in the American Nurses Association until

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HOME HEALTH KITS DIAGNOSED AS A BIG MONEY-MAKER

If you can check the anti-freeze level in your car’s radiator, why not your blood pressure? Driven by high and rising costs, alienation from professional healers, the breakdown of reliance on cooperative social healing processes, increasing self-reliance, and perhaps acceptance of the blame-the-victim philosophy, Americans have made the home-test market “the fastest growing industry in the health care arena today,” according to Mark H. Bruder, president of the recently-created Bard Home Health Care Division of C.R. Bard Inc. in New Jersey.

In the three years since home tests for pregnancy were introduced, their sales have grown to $40 million and are predicted to reach $100 million by 1982, partly because of vigorous promotion campaigns on the way. Sales of these tests jumped 44% almost instantly in January when Warner/Chilcott, a division of Warner-Lambert Co., and manufacturer of e.p.t. (early pregnancy test), the first home pregnancy test kit, and other manufacturers began advertising on television. Experts expect this success to be followed by spending $15 to $20 million annually on print and broadcast advertising by Warner and its four competitors in the U.S.—Nabisco’s J.B. Williams Inc., American Home Products’ Whithall Laboratories, Copyright Diagnostic Testing, and Bio-Dynamics (makers of Daisy 2). With this push, one executive predicts sales will grow by $10 million to $20 million annually. But that is about the same as the projected advertising expenditures, which implies that these manufacturers plan to lose money the first year or two. They apparently think it will be worth it if they can gain—or create—wide acceptance for home health testing in general and their products in particular. Indeed, the size of the potential market seems to draw executives like dreams of gold-laden continents once drew European colonizers. Says Bio-Dynamics Director of Product Management James H. Frazee, “If I take the 49 million women of childbearing age in the world and multiply that number by the times they’re likely to have missed a menstrual period, I come up with an astronomical potential for this market.”

Other weapons in this latest series of voyages of conquest:

• blood pressure kits, available since 1973, aimed at the 23 million Americans with hypertension. Retails for $20 to $185 for the deluxe version with digital read-out.

• urinary tract infection kits, soon to be available nationwide—retail for $1;

• urine tests for diabetics and blood-sugar tests for insulin-dependent diabetics;

• And there are numerous others being developed—9 by one company alone.

That bastion of petit-bourgeois medical practice—the American Medical Association—has withered before the onslaught by monopoly capital. Business Week magazine reports that the AMA “approves the concept of home testing but warns that patients should still be encouraged to see a physician—not treat themselves—if the test results indicated the need for medical treatment.”

Home health tests do indeed have a great potential for democratizing the availability of vital information about one’s health at an affordable cost. In a fully democratic and socialized health care system characterized by cooperative healing efforts between professional healers and autonomous patients, home health tests could only help. But in modern day America, these tests promise primarily to encourage the individualization and atomization of the alienated victims of the medical system who are struggling to get more information about their health from the only people they feel they can trust—themselves. —George Lowrey

Source: Business Week, 8/13/79.
DRUG STORE CHAINS SEE BIG BENEFITS OF MERCHANDISING

Now it can be told. The reason prescription counters are located in the rear of many drug stores is so a customer who wants to fill a prescription must run a gauntlet of aisles crammed with general merchandise such as sporting goods, hardware, and even cameras which “drug” stores often sell for twice their wholesale cost. Another trick used by Jack Eckerd Corp., which shares honors for largest drug store chain with Walgreen Co. and Skaggs Cos., is to project a false image of a discounter. “It advertises weekly price specials on anywhere from a dozen to 215 highly competitive drugstore items that carry low gross profit margins,” reports Business Week magazine. That gets customers into the stores, where they also buy the higher profit general merchandise items they didn’t originally intend to purchase, and may not need.

Such are the kinds of merchandising ploys—generously known in the trade as “superior merchandising”—that have propelled drugstore chains from 4,000 stores in 1960 to 12,600 outlets operated by around 700 companies. Their share of the market has risen from 22% to 49.8% during that period. But that growth is running into hard times as their expansion has saturated some markets and brought them into head-to-head competition with other chains as well as surviving independents. While the competition from chains has wiped out 13,000 of the 50,000 independent drugstores that existed in 1960, the survivors in this war of attrition are fighting back with more determination and sophistication. In North Dakota, the petit-bourgeoisie won one against big capital when they got a law passed requiring that 51% of a drugstore be owned by a pharmacist.

As the chains compete with one another, many of the small ones can be expected to be driven into bankruptcy or taken over. But that growth is running into hard times as their expansion has saturated some markets and brought them into head-to-head competition with other chains as well as surviving independents. While the competition from chains has wiped out 13,000 of the 50,000 independent drugstores that existed in 1960, the survivors in this war of attrition are fighting back with more determination and sophistication. In North Dakota, the petit-bourgeoisie won one against big capital when they got a law passed requiring that 51% of a drugstore be owned by a pharmacist.

The chains are also expanding in the health care market. Optical appliance centers and hearing aids stores, dental clinics, and the sale and leasing of convalescent aids such as hospital beds are all seen as fertile areas for expansion. So the corner drugstore, no longer on a corner, will soon cease to be a drugstore as well. Such are the ways of monopoly capitalism: mutate in order to grow in order to survive. If dinosaurs had been so smart they might still be around today—looking like pigeons.

—George Lowrey

Source: Business Week, 7/23/79.
Double Indemnity

Continued from Page 2

1964, although some Black nurses were allowed ANA entry in 1951 (6). This discrimination led to the founding of the National Medical and Dental Associations and the National Association of Colored Graduate Nurses.

Now, more than twenty years after Brown v. Board of Education made segregated education illegal, the "enlightened" health professions continue to perpetuate racial discrimination. This contributes to the appalling imbalance between the physician-population ratios of whites and Blacks—in 1974 there was one white physician for every 560 whites in the population, but only one Black physician for every 2,800 Blacks, five times worse than the ratio for whites. Similarly in 1974 there was one white dentist for every 2,500 whites, but only one Black dentist for every 12,500 Blacks (7). These ratios for Blacks are worse than those of the 1940s! (To be sure, in some instances white doctors treat Black patients and vice versa, but the pattern of white doctor-white patient and Black doctor-Black patient is still pervasive, particularly in primary care settings.)

As the civil rights movement reached higher education, a task force of the Association of American Medical Colleges (AAMC) announced in April 1970 an objective of 12 percent "representative" minority enrollment in American medical schools by 1975 (8). The AAMC included Blacks, Hispanics and Native Americans in its minority enrollment goal. The 12 percent figure, however, was roughly the percentage of only Blacks in the U.S. population in 1970. The percentage of Blacks, Hispanics and Native Americans combined in the U.S. population then was about 16 percent, actually the more "representative" goal for the AAMC.

Later figures show that American medical schools fell far below this modest 12 percent goal, not to speak of the 16 percent figure. Specifically minority enrollment increased from about 5 percent in Academic Year 1971–72 to a peak of 8.2 percent in Academic Year 1974–75. Since then the figure has levelled off at about 8 percent (see Figure 1).

The 1970 AAMC report made several additional recommendations: substantial increases in and coordination of financial aid to minorities; the creation of an "educational opportunity bank" and a network of regional centers to provide health career counseling for minority students; and expansion of the AAMC's Office of Minority Affairs, established in 1969 with grants from the U.S. Office of Economic Opportunity. Seven years later, only the last goal was achieved, according to an HEW-commissioned evaluation (9). This was largely due to a $1.5 million OEO grant to administer some 50 programs for minority students from 1969 to 1973.

A 1978 report from the AAMC now suggests that minorities will now have to wait until the year 2000 for parity! (10). Although the report comments upon the federal withdrawal of support for minorities, both fiscally and philosophically, its seven goals focus upon the various steps (and, therefore, "hurdles") which minorities encounter along the path to be-

* Asian minority groups were not among the populations included in the AAMC affirmative action programs because they are not generally underrepresented in the health professions compared to their proportions in the general population. However, they do suffer discrimination and racism in the health care system as in other aspects of American life. When not otherwise designated, minority group data in this article includes Blacks, Hispanics (specifically mainland Puerto Ricans and Mexican-Americans (Chicanos) and Native Americans, reflecting the AAMC data.
In 1974, there was one white physician for every 560 whites in the population, but only one Black physician for every 2800 Blacks, five times worse than the ratio for whites. These ratios for Blacks are worse than those of the 1940s!

The AAMC report was published during the same month that the Supreme Court announced the Bakke decision. Recently, similar concerns have been shown for minorities in dentistry. Both professions plead the traditional case, bemoaning the poverty and discrimination which have left them too few qualified minority candidates for achieving parity. This is really out of their hands, they say. So under the guise of "professional standards," the buck is passed again.

The Rise and Fall of Affirmative Action

The political pressures of the civil rights and women's movements have produced substantial gains in the numbers of minority and women students being trained in the health professions. These gains can be found prominently displayed in each field's publications, demonstrating the profession's "good faith" in seeking parity for minorities and women.

But the accomplishments are in most cases meager. Consider the traditional health professional schools of medicine, osteopathic medicine, dentistry, optometry, pharmacy and podiatry. (Nursing provides a more complicated picture, which will be addressed in a future Health/PAC Bulletin.) Of the various professional schools listed in Figures 1 and 2, minority student enrollment and Black student enrollment have substantially increased in only one (podiatry) since the Academic Year 1974–75 (that is enrollment has increased by at least one percentage point). In the other schools, minority and Black student enrollment have remained essentially constant or dropped slightly since then. Especially serious is the trend of decreasing Black enrollment since 1974 in the two largest of the professional schools, medicine and dentistry. Also, still lower levels of minority student enrollment continue in schools of osteopathic medicine, optometry and podiatry.

Within the field of pharmacy, the single field where a recovery is being made, almost all the improvement is accounted for by the four primarily Black pharmacy schools: Howard, Florida A&M, Texas Southern and Xavier Universities. These four programs account for more Black pharmacy students and graduates than all 68 predominantly white institutions combined that collectively enroll less than two percent Black pharmacy students.

While progress toward parity for minorities in the health professional schools is usually discussed in terms of total minority enrollment, these figures...
are not the most sensitive to changes in the student body. First year enrollments are frequently presented as trends by representatives of the professions, like the AAMC, typically inflated by including all repeating and re-enrolling minority students. The key issue is whether institutions are actively recruiting and retaining new minority students. If they are not, minority enrollment figures will inevitably fall in the future. The most sensitive indicator of minority participation in a field is the percentage of the first year enrollment of new minority students admitted and matriculated, excluding repeaters and re-enrollees.

The data for these minority student admissions are revealing. With the exception of Academic Year 1974-75, minority admissions to the first year of medical school have hardly changed since 1971, when the AAMC affirmative action program began (see Figure 3). What's more, Black student admissions to medical schools, again with the exception of 1974-75, have been falling quite steadily since 1971 (Figure 3). The current rates of Black medical school admissions are well below the 1971 levels!

As for dentistry, total minority admissions rates have climbed very slowly since 1971-72, but for the last three years they have stagnated at 6.8 percent. Black student admission rates, however, have slowly but steadily declined since 1971-72. Osteopathic medicine doubled its very low minority admission rate between 1973-74 and 1974-75. This level of admissions has been maintained for all under-represented minorities, but not for Blacks, whose percentage in the first year enrollments has declined since 1974-75 (Figure 3).

Thus according to this more sensitive indicator, the admission rate of new minority students, the much heralded affirmative action programs of the AAMC have had little impact on minority admissions. And since the inception of this program in 1971, the representation of Black students in these health professional schools has actually dropped. The enrollment figures used by the AAMC obscure this failure, but they will do so only temporarily—eventually, if present trends continue, these figures too will reflect the drop in Black admission rates and the stagnation in overall minority admission rates.

The worsening situation for Blacks is also reflected in the declining percentage of Black applicants accepted to medical schools (Table 1).

The enrollment of women in health professional schools presents, so far, quite a different story. In every one of the six types of schools reported there has been a steady, significant increase in the enrollment of women (see Figure 4). For example, enrollment of women in medical schools more than doubled between Academic Years 1971 and 1978, from about 11 percent to 24 percent, respectively. In optometry, female enrollment jumped from about 4 to 15 percent during the same time period. Freshman admission rates for women and minorities by individual medical school—the best and worst of them—are given in Table 2.

Only recently have there been trends that might suggest a ceiling for women entering medicine. During the last two years the number of women applying to medical schools has decreased, while current admission rates for men and women remain nearly identical. This decline in applications would suggest a plateau of about 30 percent of women's representation in medicine. This is significantly below the percentage of women in the population and the 49 percent figure for female enrollment in higher education. As noted above, minority groups have reached a similar ceiling of about 8 percent, also well below their respective proportion in the population. (The distribution of women and minority enrollments today are summarized in Table 3.)

However these seemingly fixed limits are not generally considered quotas. Current ideology holds that the levels in the 1950's that applied to Jews, white ethnics and Blacks were quotas because they were set by the institution. But today, it is said, minority students are under-represented because of lack of proper qualifications, including lack of education and lack of motivation. While these distinctions are arbitrary, the result is the same as before, low levels of most minority groups.
The anti-affirmative action backlash, inflation, institutionalized racism and changes in financial aid policy have turned the momentum of affirmative action, allowing the health professions to suspend their largely ineffectual efforts at minority recruitment in health-professional schools. The distinctions are perpetuated, often unknowingly, by advocates of affirmative action, so that the institutions and the functions which continued discrimination serves are not examined. (These myths will be discussed in the second part of this study, to be published in the next issue of the Bulletin.) Let us examine now some of the financial barriers to entrance into the health professions.

Double Indemnity: Financial Barriers to the Health Professions

Headlines greeted the emergence out of the closet of financial and class barriers to the health professional schools. In 1976 the AMA's own American Medical News announced, "Money Becoming Admissions Criterion!" But this is nothing new. The unchanging class composition of medical schools over the last sixty years provides clear evidence that class and its correlate, family income, have long been major determinants of admissions (see "Medical Education Since Flexner," Health/PAC Bulletin No. 76, May/June, 1977).

The financial barriers to the health professions should be obvious. After completing college, students must be prepared for three or more additional years of study, almost never under conditions which might allow part-time work. The expense of the training itself serves not only as an economic, but a psychological deterrent to low and middle income students. These compound barriers presented by the competition for admission, including sexual and racial stereotypes. But the costs of health professional schools are the final financial barrier to a professional education. Throughout life, persistent obstacles are placed in the paths of many women, most minority and all

### Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Applicants</th>
<th>Number of Acceptances</th>
<th>Percent Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-71</td>
<td>1,250</td>
<td>642</td>
<td>51.4</td>
</tr>
<tr>
<td>1971-72</td>
<td>1,552</td>
<td>810</td>
<td>52.2</td>
</tr>
<tr>
<td>1972-73</td>
<td>2,382</td>
<td>857</td>
<td>36.0</td>
</tr>
<tr>
<td>1973-74</td>
<td>2,227</td>
<td>977</td>
<td>44.9</td>
</tr>
<tr>
<td>1974-75</td>
<td>2,423</td>
<td>1,000</td>
<td>42.2</td>
</tr>
<tr>
<td>1975-76</td>
<td>2,288</td>
<td>931</td>
<td>40.7</td>
</tr>
<tr>
<td>1976-77</td>
<td>2,523</td>
<td>966</td>
<td>38.3</td>
</tr>
</tbody>
</table>

Schildhaus, Sam, An Exploratory Evaluation . . . of U.S. Medical Schools’ Efforts to Achieve Equal Representation of Minority Students. DHEW Publication No. (HRA) 78-735, December 1977.
### Table 2

**Affirmative Action and Inaction: Best and Worst Medical Schools**

#### Best Recruitment and Admissions

<table>
<thead>
<tr>
<th>Under-Represented Minorities (Percent Admitted) *</th>
<th>Women (Percent Admitted) †</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meharry Medical College (98.5)</td>
<td>1. Medical College of Pennsylvania (60.9)</td>
</tr>
<tr>
<td>2. Howard University (76.6)</td>
<td>2. Univ. Puerto Rico (45.8)</td>
</tr>
<tr>
<td>3. College of Medicine of New Jersey (25.5)</td>
<td>3. Univ. Missouri-Kansas City (43.4)</td>
</tr>
<tr>
<td>4. Stanford University (22.1)</td>
<td>4. Univ. California-San Francisco (42.1)</td>
</tr>
<tr>
<td>5. Univ. California-San Francisco (21.6)</td>
<td>5. Morehouse (41.7)</td>
</tr>
<tr>
<td>6. Michigan State University (21.0)</td>
<td>6. Howard University (40.3)</td>
</tr>
<tr>
<td>7. Univ. New Mexico (16.4)</td>
<td>7. Michigan State University (36.8)</td>
</tr>
<tr>
<td>8. SUNY-Buffalo (16.3)</td>
<td>8. Northeastern Ohio (36.7)</td>
</tr>
<tr>
<td>10. Cornell University (14.9)</td>
<td>10. Northwestern (33.9)</td>
</tr>
<tr>
<td>11. Harvard University (14.5)</td>
<td>11. SUNY-Buffalo (33.8)</td>
</tr>
</tbody>
</table>

#### Worst Recruitment and Admissions

<table>
<thead>
<tr>
<th>Under-Represented Minorities (Percent Admitted) ‡ ‡</th>
<th>Women (Percent Admitted) † †</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Univ. West Virginia (0)</td>
<td>1. Univ. Utah (9.0)</td>
</tr>
<tr>
<td>2. Univ. South Dakota (0)</td>
<td>2. South Alabama (13.0)</td>
</tr>
<tr>
<td>3. Albany Medical College (1.2)</td>
<td>3. Univ. Chicago-Pritzker (14.4)</td>
</tr>
<tr>
<td>4. Univ. Oregon (1.3)</td>
<td>4. Univ. West Virginia (14.8)</td>
</tr>
<tr>
<td>5. Univ. Nebraska (1.6)</td>
<td>5. Texas Tech (15.0)</td>
</tr>
<tr>
<td>6. Univ. Connecticut (1.9)</td>
<td>6. Univ. South Dakota (15.4)</td>
</tr>
<tr>
<td>7. Univ. Virginia (1.9)</td>
<td>7. Uniformed Services (15.6)</td>
</tr>
<tr>
<td>8. Johns Hopkins University (2.1)</td>
<td>8. South Florida (16.4)</td>
</tr>
<tr>
<td>10. Univ. Miami (2.3)</td>
<td>10. Vanderbilt University (16.9)</td>
</tr>
<tr>
<td>11. Univ. Tennessee (2.5)</td>
<td>11. Univ. Oregon (18.3)</td>
</tr>
</tbody>
</table>

*Percentage of minorities enrolled in first year class, 1976–77.*
†Percentage women enrolled in first year class, 1978–79.
‡ ‡ Percentage of minorities enrolled averaged over first year classes in 1975–76 and 1976–77 in schools admitting six or fewer minority students during those two years. None of these schools had fifteen or more minorities enrolled in all classes during 1976–77.
† † † Percentage of women enrolled in first year class, 1976–77.

**Sources:**

Despite the New Frontier, the Great Society and the War on Poverty, the percentage of the U.S. population which is impoverished has not substantially changed since 1969—from 12.1 percent in low-income students who aspire to a professional career.
Recently, there have been signs of a ceiling for women entering medicine. During the last two years, the number of women applying to medical schools has decreased—a decline suggesting a plateau of about 30 percent of women's representation in medicine.

But who is affected by poverty has changed dramatically. The poverty rate among the elderly dropped 41 percent from 1969 to 1976, while it rose 14 percent for children under eighteen. In 1959 the poverty rate among Blacks was three times that of whites, by 1976 the rate was three and one-half times the white rate. Women have always had less earning power than men in the United States—for example, in 1959 the female poverty rate was two-and-a-half times that of males. By 1975 the rate was four-and-a-half times the male rate. Thus the face of poverty has changed. Today the poor are younger and more likely to be female and Black than in the 1950s.

From the beginning of their educations in primary and secondary schools until their attendance at college, the poor have less of their own personal resources to spend for their education, and less government money is spent on them (12). The property tax structure which finances most primary and secondary education has led to vast discrepancies in the amount spent on each student, consistently favoring white, suburban, upper-middle class children over poor minority and urban, blue-collar children. The consequences of this are twofold: (a) members of the highest socioeconomic classes are disproportionately concentrated in the high "ability" and the lowest socioeconomic classes in the low "ability" groups among high school graduates, and (b) even among those in the highest "ability" group, fewer poor and minority students enter college, a cumulative consequence of inadequate counseling, support, and financial aid, fewer role models, lower teacher expectation and admission bias.

Table 3

Distribution of Women and Minorities in Higher Education and the Health Professional Schools, 1977-78

<table>
<thead>
<tr>
<th>Distribution by Race:</th>
<th>Percent of U.S. Population</th>
<th>Percent of All Higher Education</th>
<th>Percent of Selected Health Professional Schools*</th>
<th>Percent of Medical Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>86.6</td>
<td>81.3</td>
<td>88.2</td>
<td>86.6</td>
</tr>
<tr>
<td>Black</td>
<td>11.6</td>
<td>9.7</td>
<td>5.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Hispanic:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexican-American</td>
<td></td>
<td>4.3</td>
<td></td>
<td>1.4</td>
</tr>
<tr>
<td>(Chicano)</td>
<td></td>
<td>3.1</td>
<td></td>
<td>1.4</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td></td>
<td>0.8</td>
<td></td>
<td>0.4</td>
</tr>
<tr>
<td>Native American</td>
<td></td>
<td>0.4</td>
<td>0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>1.3</td>
<td>1.8</td>
<td>2.7</td>
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<table>
<thead>
<tr>
<th>Distribution by Gender:</th>
<th>Percent of U.S. Population</th>
<th>Percent of All Higher Education</th>
<th>Percent of Selected Health Professional Schools*</th>
<th>Percent of Medical Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>49.0</td>
<td>51.2</td>
<td>73.0</td>
<td>76.3</td>
</tr>
<tr>
<td>Women</td>
<td>51.0</td>
<td>48.8</td>
<td>27.0</td>
<td>23.7</td>
</tr>
</tbody>
</table>

*includes pharmacy, dentistry, optometry, allopathic and osteopathic medicine.

real and perceived (13,15). Affluence is the important prerequisite for higher education: over the past fifty years a 10 percent increase in family income is associated with a 12 percent increase in college enrollment (15).

Once enrolled in college a similar double bind faces poor, working class, and minority students. In all public institutions of higher education with varying degrees of selectivity the median family income of their students is directly proportional to the money and resources committed to educate each student—the higher the median income, the more money spent per student (16). Minority students are disproportionately represented in two year and four year colleges which spend the least per full-time pupil; the resources spent by highly selective universities, which have the highest median family income and lowest minority enrollments, is more than three times that spent per student by the institutions which the greatest percentage of minorities attend (16). This discrepancy is present in public institutions alone; including private institutions with their greater prestige, selectivity, and tuitions and their lower percentages of working class and minority students only make these statistics worse! Among 1974 applicants to medical schools, 66 percent of whites attended schools which had expended more than $2,500 per student, while only 55 percent of Blacks and 40 percent of Chicanos had. Both Black and white applicants from the more affluent schools are accepted at a rate one-third higher than applicants from the less endowed colleges (17).

The disadvantaged also contribute a greater percentage of their family's total income toward their education than do more affluent students. Students whose family income is less than $5,000, while only 8.2 percent of the national undergraduate body are 10.4 percent of the total relying on personal savings, 13.9 percent of those depending on earnings while taking courses, 17.5 percent of those depending upon their spouses' savings or earnings, 31.1 percent of those using Social Security benefits, and 38.8 percent of those using other sources (mostly extended family contributions) (18).

Once in college the type and amount of financial aid makes a significant difference in whether or not a minority student completes his or her schooling. The size of scholarships or grants is a major factor in the persistence of Black students in college; loans and work-study programs seem to enhance Black students' ability to stay in college, especially in predominantly white institutions (19).

The financial aid programs enacted by Congress under the Education Amendments of 1972 are beginning to have a visible impact on the access to and completion of higher education for low-income and minority group students. These aid programs include Basic Educational Opportunity Grants (BEOG), Supplemental Educational Opportunity Grants (SEOG), State Student Incen-

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* Considerable problems still exist in assessing these programs as records are not kept on all those who apply for financial aid or the dollar amounts which each recipient receives from each and all sources; although data are kept by race/national origin and sex, all the minorities are pooled and no data are available which might discern the awards made to, for example, white men or black women. Another important limitation for women and minorities is the restriction made upon part-time students, who must attend at least half-time to be eligible.
tive Grants (SSIG), College Work-Study (CWS), National Direct Student Loans (NDSL), and Guaranteed Student Loans (GSL). They accounted for $3 billion or 37 percent of the Office of Education’s fiscal budget in 1976. All these grants are awarded on the basis of financial need. While minority students made up 12 percent of all undergraduates in 1974–75, they received 33.6 percent of the total number of grants and National Direct Student Loans. Women made up 42.8 percent of full-time students, but received 51 percent of the total number of awards (although more men than women participate in multiple programs) (20).

The impact which these programs have had is considerable. For example, while the proportion of whites of college age who actually attend college has declined since 1970, the proportion of Blacks and Hispanics has increased. Thus for the population between age 16 and 34, Blacks actually had a higher percentage enrolled as of 1976 than whites (21). In 1977 for the $5,000–10,000 income range, 17 percent of all Blacks from 18 to 24 years entered college, compared to 15 percent of whites and 11 percent of Hispanics. In the $10,000–15,000 income bracket, these figures were 21 percent of Blacks and 17 percent of whites and Hispanics (22). The grants awarded consistently follow their designed intention—to assist low income students attain access to post-secondary education. Only for the private market Guaranteed Student Loans (GSL) do students whose family incomes are less than $7,000 receive less support than those whose family incomes are higher. The success and consistency of these need-based programs stand in marked contrast with the financial aid record in the health professions.

The financial barriers at the final hurdle in reaching medical or dental school despite federal commitments to equal access actually have become more formidable in the past decade. A study in 1964 of graduates of predominantly Black colleges demonstrated that 70 percent of the men and 50 percent of the women had wanted to study medicine but could not do so for financial reasons (23). In 1977 when Black undergraduates at two schools, Texas Southern and Prairie View A&M, were asked why they thought there were not more Blacks in medical schools, 69 percent of the respondents cited inadequate financial assistance as very important (24). Their impressions are an accurate assessment, for even those minority students who do

Table 4
Percentage Distribution of U.S. Medical Students by Family Income, 1976–77

<table>
<thead>
<tr>
<th>Family Income</th>
<th>All U.S.*</th>
<th>White</th>
<th>Black</th>
<th>Hispanic &amp; Indian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $5,000</td>
<td>13</td>
<td>2.9</td>
<td>22.3</td>
<td>15.6</td>
<td>5.0</td>
</tr>
<tr>
<td>$5,000 to $9,999</td>
<td>23</td>
<td>8.7</td>
<td>25.2</td>
<td>25.2</td>
<td>10.8</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>24</td>
<td>21.3</td>
<td>23.5</td>
<td>27.4</td>
<td>21.8</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>18</td>
<td>16.7</td>
<td>11.4</td>
<td>11.3</td>
<td>16.1</td>
</tr>
<tr>
<td>$20,000 or more</td>
<td>22</td>
<td>50.3</td>
<td>17.6</td>
<td>20.6</td>
<td>46.2</td>
</tr>
</tbody>
</table>

*for 1974 (from U.S. Bureau of the Census)

enter medical school are on the average significantly poorer than their peers (Table 4).

"Money is the big problem," Dario Prieto, Director of Minority Affairs at the AAMC, told the Medical Tribune. This was echoed by Dr. John Cooper, President of the AAMC. He acknowledged that minority students stopped applying to medical schools when the federal dollars began drying up, tuition and interest rates skyrocketed, and scholarships plummeted, while still suggesting that the problem might be in the eye of the beholder, "As a result, the perception that minority and other low-income students have of the indebtedness they must incur places medicine beyond their realm of possibilities, as they view it." (25) (My emphasis—H.S.) But more than psychological deterrence is at work. More than twice the proportion of minority students were already entering medical schools in debt than whites in 1974, when the declines in new enrollments began. Almost 90 percent anticipated debts before graduation with a mean anticipated debt of $13,300, four times what they entered with, which was actually an improvement from 1971 (26). Minority students continue to apply, but their acceptance rates fell (Table 1). They were not the recipients of special interest admissions (see Box).

Federal Financial Support for Health Professional Education

With financial problems a major barrier to medical education and with only half-hearted, ineffective support for integration from private groups within the health system such as the AAMC, it is no surprise that minority and women's groups have turned to the federal government for financial and political support. As noted above, federal programs appear to have had a positive impact on minority and female enrollment in other areas of higher education.

But the role of federal support for the health professional schools since 1974, although nominally designed to "increase access of students from all income levels to health professions careers" (27), has actually made access even more difficult. Federal withdrawal and reorganization of financial aid support correspond in time with the zenith of affirmative action; its demise followed directly the decline in need-based financial aid—without court order or headlines.

Early federal support for health professional education in the U.S. was built into a provision of the Social Security Act of 1935 authorizing grants to states for training and maintaining public health services. In 1952 the President's Commission on the Health Needs of the Nation called attention to shortages in health care personnel and recommended federal aid for the health professional schools, including medicine, dentistry, nursing, and public health, and again in 1958 the Surgeon General's Consultant Group on Medical Education reiterated these recommendations. The dramatic launching of Sputnik precipitated the first federal venture into direct student assistance with the National Defense Education Act (1958),

Minority students stopped applying to medical schools when the federal dollars began drying up, tuition and interest rates skyrocketed and scholarships plummeted

which has provided the precedent for all subsequent student aid. After an unsuccessful effort in 1961, the Kennedy Administration re-introduced a bill which proposed a five year student loan program and a ten year construction-grant program for medical, osteopathic, dental, nursing, optometry, podiatry, pharmacy, and public health schools. In 1963 the Health Professions Education Assistance Act was passed and signed into law (P.L. 88-129). In 1964 and 1965 the law was amended to extend the student loan program, encourage expansion through a system of grants based on the number of students in a school (called a "capitation" program), and establish a Health Professions Scholarship program. Allied health professions were included in 1966. (These were years of major federal activity in health care—Medicare and Medicaid were passed in 1965.)

The Health Manpower Act of 1968 (P.L. 90-490) integrated all of the previous legislation, extended the federal matching for construction, and provided further special project grants designed to increase enrollment and develop new types of health professionals. Many schools reported rising costs and claimed that they were unable to expand without significant additional assistance. From 1964 to 1970 more than $800 million was appropriated under this legislation with 17 percent going to student financial aid.

In 1971 the Comprehensive Health Manpower Training Act extended the loan and scholarship programs with added loan-forgiveness for serving in shortage areas. A major shift took place in the federal approach to institutional needs, moving from "last dollar" distress grants to "first dollar" operating subsidies in the form of significantly
The Sophie Davis Center: One Step Forward, Two Steps Back

In 1973 the Sophie Davis Center for Biomedical Education (Bio-Med program) was opened at City College of New York (CCNY). From the beginning, affirmative action was one of the program’s goals but not the only one. After two years of successful affirmative action, the program joined the national trend of declining minority admissions.

Two very different interest groups supported the Bio-Med program. Some of the college science faculty complained that since 1969 the quality of students had declined. In 1969 the City University of New York began a policy of “open admissions” admitting any New York City high school graduate. The science faculty wanted to attract the “good students” back to CCNY. A medical school might do the trick.

Black and Hispanic community and student organizations wanted to promote the training of physicians for their communities. One way to attain this goal was to increase the number of minority medical students, particularly Blacks and Hispanics from the city’s public schools. Robert Marshak, president of CCNY at this time, stated, “Keeping in mind their representation in the college and in New York City generally, we want to get substantial numbers of minority students” (New York Times, 6/6/73).

The Bio-Med program was structured differently from traditional medical programs. The Bio-Medical program would lead to a M.D. degree six years after high school—instead of the usual four years of college followed by four years of medical school. Students admitted to the program would spend four years at CCNY and then transfer into one of eight medical schools for the final two years of clinical training leading to the M.D.

The science faculty now had an academically rigorous training program to attract the type of students they felt would save the college from its supposed academic decline. Those who wanted to train more minority physicians saw different advantages. This program trained doctors two years faster than a traditional program. Also instead of the usual two barriers to medical education—college and medical school admissions—a student once admitted into the Bio-Med program is guaranteed a spot in one of the affiliated medical schools.

The Bio-Med program also required courses in medical sociology and politics, community organizing, epidemiology, and field experience in community agencies to help maintain and develop the students’ commitment toward urban primary care.

In September 1973 the first class admitted was in fact representative of the racial mix of the city’s high schools. Fourteen Hispanics, ten Blacks, and nine Asians were in the original class of 62. Half of the class were women. At this time Blacks and Hispanics made up one third of the New York City population and more than half of the city’s high school population.

By the time that class had completed its first year, controversy surrounded the program. In May 1974, Harry Lustig, Dean of Liberal Arts at CCNY, charged that the Bio-Med program was pressured into the use of racial quotas by community groups from Harlem—the neighborhood where CCNY is located. The oft-used charge that underqualified minority students were taking the places of better qualified students was trotted out for another go-around. B’nai B’rith began to investigate a charge of reverse discrimination brought by the father of two white students with good academic records who were not admitted.

Proponents of affirmative action insisted that the racial composition of the first class was attained while adhering to selection criteria of academic performance plus social commitment. A New York City Human Rights Commission investigation reported in the New York Times on June 8, 1974, said that “recruitment was based on commitment to serve as a physician in an urban area and represented a concern for scholastic achievement, geographical location, community sensitivity and concern, all of which are vital ingredients for bio-medical pursuits.”

Despite controversy over reverse discrimination, the Bio-Med program admitted 22 Blacks, 14 Hispanics, and 5 Asians to its second class of 68 students.

During the first two years of the program’s operation, a number of minority students ran into academic trouble. Inner-city New York schools did not offer decent preparation in science. Students, no matter how talented or motivated, could not be
expected to survive an accelerated medical program without extra academic help.

Students complained that the program brought them in but did not make a good faith effort to keep them there. The tutorial and remedial help made necessary by poor quality public schools was unavailable. Minority students were subjected to the humiliation of accusations that they were not qualified to be in the program.

The New York Post ran a series of articles "exposing" students who were given a second chance on some exams. Although make-up exams are common practice at many medical schools, the CCNY administration began to give in to the pressure. Instead of starting programs to help students with less extensive preparation, it talked about criteria for academic probation and dismissal. In Fall 1977, only 35 of the original 62 students completed the required courses at CCNY and were ready to continue to the final two years of training.

In 1975 a new admission procedure began, weighted more in favor of academic preparation. Scores in science and mathematics regents exams received more careful consideration. This eliminated many minority students from the picture, because many predominantly Black and Hispanic high schools do not even offer the courses needed to prepare for the regents exams. The Bio-Med classes of 1975-1978 slid back toward the national average number of minority students. Increasingly, more students came from suburban and middle-class backgrounds.

The commitment to bring the "good students" back to CCNY took priority over the need to change the complexion of medical school classes. As the number of minority students from the inner-city fell, so did the level of students' interest in primary care and community health. The instructors of the community health courses had a hard time interesting suburban students in urban community health.

Anti-affirmative action forces in the program received legal blessing in August 1976. Despite the fact that affirmative action was on its way to being discarded, B'nai B'rith and the Italian American Center for Urban Affairs failed a Bakke-like suit to guarantee that affirmative action would not be practiced at the Bio-Med program. On August 18, 1976, Federal Judge Marvin Frankel found that "19 whites and Asians had been intentionally eliminated on the basis of race from the list of students selected in 1974."

The selection process which resulted in a high proportion of minority students was not the main issue of the suit. If the Bio-Med program selected students based on criteria giving social commitment and academic performance equal weight, as it did during the first two years of the program, the court's ruling might not have been made. The court found fault with the process used to fill places of students who were invited to attend the program but decided not to. Race could not be the sole criterion for calling people off the waiting list, because this implies the existence of so-called "Black slots" and "Hispanic slots."

Between 1975 and now, the CCNY science faculty who see the Bio-Med program as a method to up-grade academic standards at CCNY have had the upper hand. This year the advocates of urban community medicine have made some gains. The Fall 1979 entering class has about 18 percent Blacks and Hispanics and 11 percent Asians. According to Jack Geiger, professor of community medicine at the program, several factors contributed to this advance.

A new program called the Bridge to Medicine provides science education for selected high school students. If the science classes they need are not available at their schools, they take the required courses at City College. Several of the incoming students were in this program.

Programs are starting to recruit Bio-Med students from the families of the members of New York City labor unions. An option for students to go through in seven or eight years instead of the very intense six is being developed.

Whether the Bio-Med program can continue to admit minority students at an increasing rate and provide the support necessary to keep these students remains to be seen. In a period of a downward trend in minority medical school admissions and decreasing support for affirmative action in employment and education, it will be a struggle.

—Richard Younge
larger grants allocated on a per-student basis if schools agreed to expand. The effort to influence specialty choice and geographic distribution and to increase the proportion of minority students was made through special project grants to schools. This included support for regional health centers, family medicine departments and general Admissions to the health professional schools have largely replicated the existing hierarchy in the society, in the profession, and, particularly, in the schools themselves.

dentistry training programs, and projects designed for "identifying, recruiting, and selecting individuals from disadvantaged backgrounds." These programs were to facilitate entry of disadvantaged students, provide counseling and other services to retain them, provide pre-admission programs, and publicize sources of financial aid. These newer efforts to affect specialty choice and geographic distribution and to increase minority students were, in effect, voluntary for the schools as they provided the "carrot" of aid without the "stick" of active enforcement of the conditions for the aid written into the law. Almost immediately after the passage of this Comprehensive Manpower legislation a re-examination of federal health manpower policy began. The doctor shortage was understood more clearly to reflect maldistribution of physicians by medical specialty and geography, which even a substantial increase in traditionally selected and trained health professionals would not relieve. Still the language and cultural barriers to health care were not addressed. Nor was the evidence that low income students traditionally choose primary care practices even without incentives or obligation and that professionals of all racial and ethnic groups largely serve their own communities (28). Nor was the evidence of the ineffectiveness of capitation grants as a means of promoting access examined (29, 30).

In 1973 Congress established the first programs—the Public Health Service and Physician Shortage Area scholarships—to provide financial aid in exchange for an obligation to serve in a shortage area without regard for financial need. A similar Armed Forces scholarship was established under the Department of Defense to meet the military's physician needs. In 1974 a complete phase-out of the Health Professions Scholarships was begun, and support for the loan program began to decline.

After the House–Senate Conference committee could not agree on how to achieve geographic and specialty redistribution during the preceding Congress, a consensus emerged that resulted in the Health Professions Educational Assistance Act of 1976 (P.L. 94–484). As amended in 1977, its major student financial assistance programs include the following:

—National Health Service Corps (NHSC) scholarships—an expanded continuation of service-obligated financial aid awarded without regard for financial need;
—Health Professions Student Loans (HPSL)—continued at diminished levels and limited to students with "exceptional financial need" with interest raised from 3 to 7 percent;

---Scholarships for Exceptional Financial Need (EFN)—need-based financial aid without a service obligation for first year students only; and
—Health Education Assistance Loans (HEAL)—new, federally-insured bank loans at 12 percent (plus a 2 percent insurance premium) without subsidies (see Financial Aid Sources, page 27).

After the Act was signed by President Ford on October 12, 1976, almost two years passed before the publication of the regulations for its student aid programs. Regulations for two of the programs (EFN and HEAL) were published during the summer of 1978, without opportunity for public comment. As a result, for almost three years health professions financial aid was in limbo.

Continued on Page 25
CBC: WHAT'S PREVENTING A HEALTH POLITICS?

In late September the Congressional Black Caucus (CBC) held its annual Conference here, with upwards of 10,000 people participating in events, looking intensely toward 1980 and the 1980's. No "candidates," including President Carter and Senator Kennedy, were asked to speak to the Caucus this year. They had "debated" back-to-back the year before. The meeting came, however, just as the growing gleam in the eye of the Senator still known as "Mr. National Health Insurance" was giving earlier-than-expected birth to candidacy.

Representative John Conyers, Jr. (D-MI), who is leading a "dump Carter" movement, declared: "We put him in office. We can't let someone else take him out."

A sharply critical report was released before the Caucus conference stressing the limits of specific Administration programs and performance thus far, including health and health services. The personal politics of fund-raising and survival appeared to be the order of the day.

No gathering of office-holders can match CBC for its range of individual political commitments and increasing Congressional responsibilities essential to a "new public health movement"—funding priority for preventive and primary health services, equality and appropriateness for medical services, and occupational/environmental/social health action. Together with Labor and the broader progressive alliances, CBC individuals have articulated a call not only for civil rights in health but for public services commitment for low-income communities, for health planning for the neediest consumers, and for public action regarding the inner city environment.

Meanwhile, sixteen of the seventeen CBC Congress-people are urban Democrats, one is an urban Republican; none are U.S. Senators. Caucus Health "Brain Trust" convener, Congressman Louis Stokes of Cleveland, is on the Labor/HEW Appropriations Committee. Not visible on health policy questions as such, he is an important advocate, for example, for community health center and child health assessment program funding. This is in close cooperation with groups like the National Association of Community Health Centers.

Congressman Ronald Dellums has gained the support of much of the Caucus as at least courtesy co-sponsors of his radical National Health Services Bill (see, Washington Column, Nov.-Dec., 1977).

Dellums directly addresses health policy in the Congress only as Chairman of the District of Columbia Committee and as part of military and foreign policy committee issues. For example, his Infant Nutrition Act of 1979 would prohibit sales promotion of baby bottle formula in underdeveloped countries by U.S. companies, requiring proof that formula will only reach those who can use it safely.

Rep. Charles Rangel (D-NY), among others in the Caucus, has meanwhile been saddled with the President's watered-down Hospital Cost-Containment Bill—thus taking the full attack from the Medical Lobby (including the American Hospital Association, the Federation of American Hospitals, and the American Medical Association). The Lobby asks, for its part, why the basic necessity of health services alone should be singled out for Administrative pressure and held hostage against comprehensive NHI when government industry and bank-subsidizing policies escalate costs without such restraint in energy, food, and housing. There are certainly doubts whether the proposed voluntary-transitional ceiling approach will actually cut inflation for people.

In this Congressional term, Rangel became Chairman of the Health Subcommittee of the House Rules Committee, from which national health financing and hospital cost-containment emanates. Reportedly wrangling Carter Administration support as he voted at the end of the last Congressional session for Carter's natural gas price deregulation, Rangel apparently has also been given some HEW review power on health projects close to home in Harlem. Rangel is "courtesy" introducer of the President's National Health Insurance package, but is additionally considering a maverick financing bill of his own.
own, probably along with James Corman (D-CA), who broke "to the left" of Kennedy.

Demonstrating determined savvy as a health-oriented freshman CBC Member is Mickey Leland, who now holds Barbara Jordan's old seat from Houston, Texas. The May '79 CHAN Newsletter of the Consumer Coalition for Health (CCH) and the Public Citizen Health Research Group lauds Leland's role "in mobilizing support from the Congressional Black Caucus" and firmly encouraging Rep. Henry Waxman (D-CA and new Chairman of the House Health and Environment Subcommittee) "to break with the conservative majority on the Subcommittee and work hard on the full Committee to restore civil rights and consumer protection" in the recent health planning renewal and amendments showdowns.

Leland, a founding member of the Houston chapter of the Medical Committee for Human Rights, is a pharmacy-trained activist who has long had an interest in consumer health and civil rights issues. As a Texas state legislator, he chaired successful committee action in that conservative chamber on issues like generic drug substitution and Health Maintenance Organization enablement. A co-sponsor of the Deluims Bill, but more recently visible as a Kennedy Bill Co-Introducer, Leland appears to be focusing on particular health consumer rights and environmental protection legislation where some Congressional committee leverage can be developed now.

Congressmen Parren Mitchell (D-MD) and Conyers both have been outspoken on inner city environmental problems. Freshman Congressman William Gray of Philadelphia, who has become interested in occupational health issues, keynoted a local conference last spring on industrial cancer.

The inability of the Caucus yet to generate bold, unified representation on the health and health services issue—especially those currently impacting inner-city minorities—lies neither in individual failures to grasp policy nor simply in the quandry of trying to carry progressive agendas against a regressive national political climate. Rather, there is a decided tendency for deeper urban health questions and alternative strategies to get lost in the fragmentation of Congressional committee and Executive agency business. This fragmentation is fed by the limits and contradictions of both Kennedy and Carter approaches for medical care financing and regulation, and divisions in the House of Labor between, for example, the old health insurance lobby and new occupational health movements. It is paralleled by the desperate search by Black political leaders for any unified leverage for minority-assisting economic development. There are some few rewards for particular leadership stances in relation to current Party leaders. There is a vast "mobilization of bias" against root issues such as the relation between health services and urban survival being legitimately linked together in the political arena.

Even in the quickly reshuffling momentum of internal Party conflict, Blacks and Hispanics who were the most committed voting groups in 1976 for Carter, might re-pose, in the Democratic Party and outside, basic social commitment issues including health and health services.

But the 'Eighties health politics of economic and fiscal scarcity, frightening corporate industrial illness, and of the limited regulation for assuring any guarantee of equal distribution of efficacious medicine cannot be answered simply by a 'Sixties chorus for more loose federal entitlements and authorizations.

Basic questions need to be debated and understood if the political coalition around health issues is to be built. Which corporate entities specifically are threatening our lives and health and those now of our children's children? What local services are we defending to maintain or effectively expand? Exactly how are we to regulate, allocate and reorganize the medical technology and caring resources that now distort community-based and caring and public health action?

Until there is a more unified and activist organizing base to support actions of the CBC—opposed by powerful lobbies and a pervasive conservative atmosphere—the Caucus probably is not the place to expect a new public health politics to emerge.

There are health programs in the jurisdiction of the inner cities represented in the Caucus which might prove to be better models to support than the currently available policy positions on the Hill. The New York Post recently chided embattled New York City health planners for overlooking networks of health centers which "now flourish in several major cities, including Chicago, Detroit ...and Newark." The Post concluded: "Perhaps the... experts should simply have visited New Jersey."

Between this September in Washington and next August at the Democratic Convention in New York City a Black political convention that also re-examines its role in an overall progressive block could be generated from turf other than the currently burned-over zone of the Potomac.

Maybe they'll meet in New Jersey ...

—Robb Burlage
LOST TIME AND LOST LIVES

Last June, the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor finally came out with its summary of occupational injuries and illness for 1977. The results are disturbing to those concerned about worker health and safety. And they will almost certainly provide ammunition to those vocal business and political interests who have long sought to undermine the current occupational health and safety movement and to destroy the federal OSHA agency.

The BLS report, entitled "Occupational Injuries and Illnesses in 1977: Summary," (Report No. 561; June, 1979) announced a 6 percent increase in the rate of lost time injuries and illness for manufacturing workers between 1976 and 1977—from 4.8 to 5.1 lost workday incidents per 100 workers per year. As seen in the accompanying graph, the lost time rate for manufacturing has increased from 4.2 lost time injuries and illness per 100 workers in 1972 to 5.1 in 1977, an increase of 21 percent! Remember, this comes on top of a 29 percent increase in this rate between 1961 and 1970; and this was one of the key factors in building support for passage of the OSHA Act in 1970 (see, for example, Ashford, Crisis in the Workplace, p. 46 or the Health/PAC Bulletin, No. 44, September 1972, p. 15). So in OSHA's first six years, it has not been able to stem the rising tide of injuries and illness on the job which helped prompt the law's passage in the first place. Indeed, if anything, the picture today with respect to disabling injuries and illness is worse than when OSHA was passed in 1970.

But working people and their families, as well as other ordinary Americans, expect and deserve something better from OSHA. They have supported OSHA—and, I believe, will support it—so long as it shows a record of accomplishment in protecting the lives and health of American working people.

I believe OSHA has won support in the past for its actions in regulating health hazards such as asbestos, polyvinyl chloride plastic and DBCP insecticide. During the 1972-1977 period discussed above, the annual occupational death rate has dropped by 2.5 percent, a small drop but a move in the right direction. And, I suspect, the large fines levied against companies responsible for major disasters involving loss of lives—fines tens and hundreds of times larger than similar OSHA fines in the past—are welcomed as a warning to large companies that avoidable disasters are being taken seriously, even though this action won't help the workers who died.

If OSHA is to improve its safety record, it will have to expand the scope of its safety standards to cover a great many more unsafe situations than it now does.

But for every fatality caused by the job there are roughly 500 lost-time injuries and illnesses, a total of 2.2 million of them reported in 1977. And most of OSHA's enforcement resources go into the safety part of inspections. Ordinary citizens legitimately expect this vast effort of OSHA inspectors and expenditure of OSHA resources to pay off in a reduced or at least stable rate of injuries, rather than the ever increasing rate which is now the case.
Some people in OSHA have apparently been trying to wish away this problem by asserting, at least informally, that the disabling injury rate hasn't really been rising recently, it just looks that way because the reporting of lost time injuries is getting better. This sounds like a tune from the late, unlamented J. Edgar Hoover's songbook—rapes and other violent crimes are not going up, they're just being reported more often—and it's just as badly off-key. For if the rise in serious manufacturing injuries was only due to better reporting, then we would expect to see a similar rise in other employment sectors and we don't see them. For example, in the same six year period 1972-1977, disabling injuries and illness in the construction industry fell by 2 percent. The corresponding rates in the trade and service sectors went up in the same period, but only by 4 and 10 percent, respectively. In short, of the seven other employment sectors besides manufacturing, none rose more than 10 percent in this period, except transportation and public utilities (18%). So the 21 percent rise in the manufacturing injury rate stands out among employment sectors. It must be taken as a real rise in disabling injuries and be acted upon accordingly.

In light of the above, is OSHA doing any good at all in the safety area? Yes, it is, I believe, but not anywhere good enough. This view is given support by a recent study entitled "Regulating Safety: An Economic and Political Analysis of Occupational Safety and Health Policy" by John Mendeloff (MIT Press, 1979). The author analyzes statistics involving disabling injuries and illness for the state of California between 1948 and 1975. He shows that based on trends in the pre-OSHA period (1948-1970), the current high disabling injury rates would be even higher without OSHA. He estimates that in California OSHA has cut down the rate of lost-time injuries and illness for manufacturing workers by 3 to 5 percent. The reason this number is so low, he shows, is that only 5 to 10 percent of all disabling injuries and illness result from detectable violations of OSHA safety standards.

This suggests that if OSHA is to improve its safety record, it will have to expand the scope of its safety standards to cover a great many more unsafe situations than it now does. If it can't or won't do this, it can expect grave political problems, since its business and political enemies will surely make the general public aware of the agency's failures. Health and safety activists should press OSHA on this matter and, even more important, give safety issues the kind of careful attention they have always deserved but not often been given.

—David Kotelchuck
A NATIONAL VOICE
FOR WOMEN'S
HEALTH CONCERNS

"When I appeared as an expert witness before Senator Kennedy's Subcommittee on Health Hearings on DES in 1975, it was clear to me that the Women's Health Movement had had little impact at the federal level. There was an obvious need for efforts at both the grassroots and national levels," said Belita Cowan, one of the five founders of the National Women's Health Network (NWHN). And so, Ms. Cowan, Phyllis Chesler, Mary Howell, Barbara Seaman, and Alice Wolfson formed the NWHN, a non-profit organization representing more than 1,000 health groups and individuals across the country, including the American Foundation for Maternal and Child Health, and the Boston Women's Health Book Collective, authors of Our Bodies, Ourselves and Ourselves and Our Children.

The Network serves as a communications and action network for the Women's Health Movement in this country. Network News, a bi-monthly newsletter, and emergency NewsAlerts serve to disseminate critical information on women's health issues. At the federal level, the Network presents a feminist health perspective to Congress and the health regulatory agencies. The NWHN is an educational group which presents its findings and analyses in the form of testimony at the invitation of Congress rather than lobbying. An equally crucial role at the federal level is that of monitoring the health policy developments of agencies, organizations, and the Congress itself.

The Network sends out NewsAlerts to its membership whenever local actions and initiatives are necessary.

The Network focuses much of its activity on issues of reproductive freedom including safe contraception, safe childbirth practices and safe, legal abortions, as well as campaigns against sterilization abuse and overprescribed menopausal estrogen drugs.

"National Women's Health Network regards access to safe, legal abortions as a basic right of all women irrespective of age or marital or economic status. . . . The Network is irrevocably opposed to the elimination of public funds to finance abortions for low income women, as an erosion of equal rights under the law, and insupportable limitation of the choice of women to whom society gives the fewest options, and an example of legislated class discrimination which endangers the lives and health of the women whom it affects. . . . Lack of financial access to abortion services forces many women to accept sterilization as a form of birth control, losing their childbearing capacity forever because they fear pregnancy in adverse circumstances. . . . The right to abortion is inextricably intertwined with a number of other issues, whose ultimate resolution may make abortion a crucial but less frequently exercised right. The NWHN supports struggles around these issues, particularly the fight against sterilization abuse, and the movements for child care services and pregnancy disability rights. . . . [The NWHN] opposes the use of arguments and policies on the abortion issue which stem from an analysis which suggests that population control is an element in the movement for reproductive rights. . . . The NWHN does not support the population control analysis. It takes its stand on the inalienable right of each woman to control her body and her life."

Two of the most visible actions organized by the NWHN on the abortion question were the August 11 Day of Outrage in 1977 and the Mother's Day/Motherhood by Choice march in Washington in 1978. Less well-publicized was their strong objection to the February, 1979, meeting called by National NOW to bring pro-choice and anti-abortion groups together "to seek ways to lessen the need for abortion, to reduce the incidence of unwanted pregnancy, and to end the polarization and violence surrounding the abortion issue."

Contraception has long been a concern of women's health activities—especially the assurance of safe, accessible contraception for all women who want it. Of equal importance is the need for informed consent, in all aspects of health care, but especially in this respect. As part of this concern, the NWHN testified before the U.S. Senate and the House Select Committee on Population in May 1978, the FDA Symposium on Over-the-Counter vaginal contraceptives and Health Research Group birth control pill hearings. In 1977, the Network developed an IUD information compliance survey with the Federation of Organizations for Professional Women. The Network has addressed itself to the issue of estrogen use, drug reform, and patient
At Congressional hearings, witnesses testified that Depo-Provera was especially appropriate for those of 'low income status,' the 'illiterate or semilliterate' and the 'unmotivated.' In the U.S., this is substantiated by the fact that the drug is largely administered to poor, minority, mentally retarded and institutionalized women packet inserts. Currently, the most visible project in this arena is the Depo-Provera Registry and education campaign.

Depo-Provera (medroxy progesterone acetate), manufactured by the Upjohn Company, is not approved by the FDA for contraceptive use, for use in pregnancy, for the treatment of endometriosis, or for inducing a woman's menstrual period as a "pregnancy test." However, since 1973 it has been approved for use as a palliative treatment for incurable uterine cancer (3). The FDA considers the drug experimental for use as a contraceptive. Some of its more serious side effects include the possible increased risk of breast and cervical cancer, congenital malformations in children exposed in utero, irregular bleeding patterns, prolonged menstrual bleeding, decreased libido, loss of hair, acute depression, and delayed return to fertility or possibly permanent infertility. Depo-Provera has caused endometrial cancer in rhesus monkeys (according to an as yet unpublished ten-year study by the Upjohn Company) and malignant breast tumors in female beagles.

In March, 1978, the FDA refused to approve Depo-Provera (known as "The Shot") as a contraceptive, "saying the benefits would not outweigh the risks." Upjohn appealed the rejection and cited the drug's use as a contraceptive in more than 60 countries" (4). An informal survey, conducted by the Institute for the Study of Medical Ethics in 1977, found that 16 of 50 Los Angeles physicians prescribe the drug for contraceptive purposes (5). In fact, it is estimated that "3 to 5 million women presently use this drug as a contraceptive worldwide" (6).

At Congressional hearings before the House Select Committee on Population, August 1978, witnesses testified that Depo-Provera's use was especially appropriate for those of "low economic status," for "the illiterate or semiliterate woman" and for the "unmotivated" (7). In the U.S., this is substantiated by the fact that the drug is largely administered to poor, minority, mentally retarded, and institutionalized women (8).

Because of its questionable safety and its racist usage, Depo-Provera has become a major target of NWHN activity. A national Registry has been established to enable the Network "to identify and to assist women who may have been injured by the drug," according to Cowan. The Network has also sent protest letters to the AMA, and will soon give testimony to the FDA, urging non-approval of Depo-Provera as a contraceptive and that FDA alert physicians and the public to its risks.

Any member of the Network is eligible for election to its 14 member Board of Directors. "The composition of the Board of Directors shall attempt to reflect the broad spectrum of the potential membership" (9). The current board, according to Cowan, is representative of all components of the Network's membership (race, age, geography, constituency, collectives, providers and consumers). Some of the other group members include East Harlem Council for Human Services, Coalition for the Medical Rights of Women, American College of Nurse-Midwives, Feminist Women's Health Centers, Philadelphia Women's Health Concerns Committee, and UAW Solidarity House. The dues structure differentiates between individuals, unemployed/low income members, women's, health or consumer groups, and businesses.

For further information on the Network, write to them at:
National Women's Health Network
Parklane Building
Suite 105
2025 "I" Street NW
Washington, D.C. 20006
—Marilynn Norinsky

REFERENCES

2. from telegram sent by National NOW as invitation to February 15, 1979, meeting in Washington, D.C.
6. Philip Cortman, Director of the Center for Population Research, quoted in Network NewsAlert on Depo-Provera, National Women's Health Network.
8. Ibid.
THE FIFTH COLUMN

TWO HAT TROUBLES

The union organizing program of the American Nurses Association (ANA), run through the state nurse associations (SNAs), is in serious trouble. By their own figures, the number of members under contract has recently declined from 100,000 to 75,000.

A number of complex factors are responsible for this decline. Prominent among them are lack of commitment to serious organizing and economic issues on the part of professionalist-oriented SNA leaderships, and appreciation of this lack of commitment by the rank-and-file which has led to breakaway movements, and recently increased competition from established unions.

The most extreme example of lack of commitment is that of the Texas Nurses Association (TNA). Last April, the TNA convention voted to get out of the organizing business. Not only is the TNA not going to organize any more units, but it is actually moving to decertify itself as the collective bargaining agent in the units it has already won.

While first citing the perpetual problem of workers and management belonging to the same organization, the TNA resolution goes on to state its most serious concerns, "(W)hereas, the political atmosphere in Texas is such that unionism is seen as interfering with an individual's right to work, the continuation of collective bargaining activity can be a deterrent to other activities of the TNA, including legislative issues." A clearer statement of SNA priorities would be difficult to find.

One of the largest breakaway movements has occurred in Wisconsin, where 1200 nurses voted to break with the Wisconsin Nurses Association (WNA) over its refusal to make needed by-law changes, or to commit sufficient resources to serve the rank-and-file.

The WNA resisted efforts to insulate bargaining units from hospital charges of conflict of interests. (See Bulletin, No. 80, p. 9). Last year, the WNA withdrew a petition for election at a Green Bay hospital rather than face charges of management domination, leaving the working nurses high and dry. It seems that a nursing supervisor at the hospital was also the president-elect of the WNA.

The organized Wisconsin nurses, now the United Professionals for Quality Health Care, also became incensed when it was learned that of their $105 a year mandatory dues, only $65 was being used for collective bargaining related purposes. Wisconsin is by no means the only SNA which depends on the dues of unionized members to underwrite its other activities. In states where the 1985 Proposal and similar legislation is being actively promoted, working nurses are thereby paying to have themselves stabbed in the back!

What will become of independent unions such as the United Professionals remains to be seen. Many of them retain undiluted professional conceptions, and do not yet appreciate the need for unity with other health workers. Effective representation requires tight organization, money, experience and expertise—components which newly launched independent unions are generally short of. Ultimately, independent unions must address the question of amalgamation.

The major contenders in the nursing field are the League of Registered Nurses of 1199, and the American Federation of Teachers. 1199 formed its nurse division two years ago following a successful drive at Brookdale Medical Center in Brooklyn. Since then, 1199 has registered successes and made contacts locally and nationally.

The AFT's nursing division is one year old. It is financed by a $1 million war chest, and captained by a number of ex-ANA staffers.

The major distinction between the two is that 1199 organizes nurses into a division which is part of a larger, industry-wide union, while the AFT is apparently organizing on a craft union, professional-only basis in much the same way as the SNAs.

The New York State Nurses Association refuses to believe that nurses could possible vote for anything but the professional organization...
A major showdown is coming in New York. The contract covering more than six thousand nurses in the municipal hospital system, now represented by the New York State Nurses Association (NYSNA) is up for renewal in early 1980. Both 1199 and the AFT have launched vigorous organizing campaigns among municipal nurses to bring a new election.

The loss of six thousand nurses in one fell swoop could cause the entire SNA representation system to come unglued. The victor would have instant authority.

The NYSNA, however, is taking the challenge in a cavalier mood. They apparently refuse to believe that nurses could possibly vote for anything but the professional organization. One of the challengers stands a good chance of success given the "low profile" that the NYSNA has maintained in the city hospitals until recently. It will be particularly fitting that a blow with such national implications should strike the NYSNA, the vanguard of professionalism among the SNAs.

These developments from inside and outside of the SNAs might have the effect of further isolating union-conscious working nurses from the professional organizations. To a certain extent, the SNAs undertook unionization of nurses out of fear of being swept aside by activist working nurses. It is not fair to say, however, that all SNAs are abject failures at representing nurses, or that all unions are without flaws. A few SNAs, such as California, have at times effectively represented working nurses. Therefore, it is necessary to look at the merits of individual situations.

Perhaps the day will come when the ANA and the SNAs which refuse to fight effectively for the real interests of working nurses will be limited to the nurses they represent best—supervisors, educators and graduate degree holders. —Glenn Jenkins

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The Impact of Federal Funding and Financial Aid on Affirmative Action

The three stated objectives for federal involvement in health professions education are: (a) increasing the aggregate supply of health professionals, (b) improving the geographic and specialty distribution of these professionals, and (c) increasing access of students from all income levels to health professional education. With general expansion of the social services, including the health sector, and fear of a doctor shortage during the late 1960s and early 1970s, academic health centers and the federal government found in these priorities a common self-interest.

The first priority, increasing medical personnel, has been achieved. So much so, in fact, that dramatic expansion of the health professions has now created fears of a doctor excess, with its attendant high salary and equipment costs and its impact in driving up medical cost inflation. The second priority, geographic and specialty reallocation, has proved more knotty. Mild constraints such as easily met "quotas" for primary care training as a prerequisite for capitation and service-obligated financial aid, as well as new actors within the old medical hierarchy, such as family medicine and mid-level practitioners, have performed cosmetic surgery but have not had much impact on maldistribution of physicians.

The goal of direct student financial assistance had been to increase access to the health professions for low income students and, thus, stimulate applications which would then allow the schools to be more selective and improve quality (31). From 1965 to 1973 a total of $295.3 million were allocated for loans and scholarships to the health professions schools for students with "exceptional financial need." Linking access to increased competition did inflate grade and test scores, but it actually reduced the representation of low income students between 1963 and 1967 (23). (See Table 5.) It proved a windfall for affluent students and for the schools.

Between 1970-71 and 1974-75 successful political pressure for increased minority enrollments dramatically increased funding of the scholarship and loan programs and produced a "filter-down" effect of increased aid to minority students. For example, in 1971, 40 percent of Blacks, 34 percent of Native Americans, 27 percent of Spanish-surnamed, and 26 percent of Asians received federal scholarships compared to 22 percent for all medical students (32). As a re-

### Table 5

<table>
<thead>
<tr>
<th>Academic Year:</th>
<th>Less than $5000</th>
<th>$5,000 to $9,999</th>
<th>$10,000 to $14,999</th>
<th>$15,000 to $19,999</th>
<th>$20,000 to $24,999</th>
<th>$25,000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med.</td>
<td>15%</td>
<td>36%</td>
<td>20</td>
<td>15</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>All U.S.</td>
<td>36%</td>
<td>44%</td>
<td>44</td>
<td>41</td>
<td>41</td>
<td>41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Academic Year:</th>
<th>Med.</th>
<th>All U.S.</th>
<th>Med.</th>
<th>All U.S.</th>
<th>Med.</th>
<th>All U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963°</td>
<td>9%</td>
<td>25%</td>
<td>6%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1967°</td>
<td>28%</td>
<td>41%</td>
<td>11%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1974°</td>
<td>22%</td>
<td>22%</td>
<td>18%</td>
<td>24%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Ratio of Median Income of Medical Student Families to All U.S. Families | 1.59 | 1.63 | 1.58 |


Table 6
Distribution of Selected Financial Aid Programs for Medical Students by Family Income, 1974–75

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Health Professional</th>
<th>Public Health Service</th>
<th>Armed Forces</th>
<th>Nat. Med. Fellowship</th>
<th>Guaranteed Student</th>
<th>Health Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>24.2</td>
<td>17.5</td>
<td>17.2</td>
<td>45.2</td>
<td>21.0</td>
<td>27.9</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>37.3</td>
<td>17.5</td>
<td>23.7</td>
<td>29.0</td>
<td>23.5</td>
<td>27.8</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>23.6</td>
<td>13.1</td>
<td>22.3</td>
<td>12.9</td>
<td>19.5</td>
<td>18.6</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>10.0</td>
<td>27.5</td>
<td>19.9</td>
<td>9.7</td>
<td>22.9</td>
<td>18.2</td>
</tr>
<tr>
<td>More than $30,000</td>
<td>4.8</td>
<td>24.4</td>
<td>16.9</td>
<td>3.2</td>
<td>13.1</td>
<td>7.8</td>
</tr>
</tbody>
</table>

100%                        100%                        100%                  100%                        100%                  100%


The Bakke case has merely diverted attention from the responsibility and complicity of academic institutions in draining the affirmative action movement of its momentum and funding.

years combined support for affirmative action through the Bureau of Health Manpower—that is, formula and special projects grants, as well as student loans and scholarships—decreased almost $103 million!

A study assessing affirmative action efforts for HEW noted a direct correspondence between federal funding and increases in minority enrollment:

While non-minority enrollment has continued to increase, minority first-year enrollment has followed the same pattern of change as the levels of Bureau of Health Manpower funding except for an apparent one year delay. The sharp increase in BHM support in 1973–74 was reflected in increased minority student enrollment during the 1974–75 academic year. Similarly, the drop in BHM funding to below the Fiscal Year 1973 level appeared to result in a significant drop in the number of nonrepeating, first-year minority students enrolled in U.S. medical schools. Thus, the substantial changes in the two most recent Fiscal Years, after a generally increasing trend of funds support, appears to have had major effects on the enrollment levels of minority students in medical education (9).

They attributed this change to the costs to the schools of these more expensive students who require more financial aid and are more likely to repeat years or take a decelerated course. Decreasing capitation and financial aid and the increasing costs of inflation made schools even more reluctant to admit low income students. Minority programs, as usual, were on "soft money" and lacked institutional support. The headlines appropriately began reading, "Money Becoming Admissions Criterion" (33).

As this funding support waned, so did the very concept of "need-based" financial aid. For twelve years, in which these programs largely supported the sons of professionals, no question of "equity" was raised. But when minorities and women first began entering the health professions schools and benefitting, the Republican Administrations conveniently recognized that graduation from these schools virtually assured comfortable incomes and a "high rate of return" on their educational investment (28). Only then did they question the equity of non-service-obligated subsidies. Not only did this new policy deny those historically most likely to serve in shortage areas of "need-based" assistance, it began to concentrate more
Financial Aid Sources from the Health Professions
Education Assistance Act of 1976

**National Health Service Corps (NHSC) scholarships:** recipients receive tuition, educational expenses, and a monthly stipend and are, in turn obligated to serve in a shortage area for each year of scholarship support; applicants who have second thoughts and fail to accept the scholarship are liable for damages of $1,500. The penalty for failing to fulfill the service obligation is three times the total scholarship assistance plus interest at the maximum prevailing rate, payable in one year. Priority for awards are to be given to first year students and are sex- and color-blind. Awards are made without regard for financial need.

**Health Professions Student Loans (HPSL):** loan pool is funded at diminished levels through 1980. Loans are limited to students with “exceptional financial need” and limited to an annual maximum adjusted to tuition costs. Interest is raised from 3 to 7 percent.

**Scholarships for Exceptional Financial Need (EFN):** need-based financial aid with the same benefits as the NHSC scholarships but without a service obligation, but limited to two first year students at each medical, osteopathic, and dental school and one first year student at other health professions schools.

**Health Education Assistance Loans (HEAL):** new, federally insured bank loans administered by the Office of Education rather than the Bureau of Health Manpower and modeled after the guaranteed student loans. The loans are limited to $10,000 annually and only half of any medical school class may borrow in this program. The interest rate ceiling is 12 percent (plus a 2 percent insurance premium) without subsidies; interest must be paid by the student or accrued while in school. Forgiveness of these loans for service in shortage areas is at the discretion of HEW.

Federal dollars on fewer, more affluent students (Table 6)! Still, Cliff Allen, Director of the Division of Financial Aid at the Bureau of Health Manpower, can say without irony that these changes will have “no effect” on the composition of the health professions’ student body and that the priority is putting “a cap on funding.” Already during the last two years there have been the first declines in more than fifteen years in the number of applicants to medical and dental schools, primarily due to the loss of lower and lower-middle income applicants (34).

The private sector yields a similar story. The National Medical Fellowships program, founded in 1946 to increase opportunities in medicine for Blacks and expanded in 1970 to include other minorities, has followed the same trajectory as the Health Professions Scholarship and Loan funding. Although the total number of Blacks and minorities entering medical schools has leveled off since 1975–76, the NMF awards peaked in numbers in 1974–75 and in dollars in 1973–74, and continue to decline. In 1978, in order to eliminate a deficit and achieve long-term stability, the NMF scholarships fell below their 1971 number and their 1970 total amount (35). Another major source of private financial aid support ended in 1976–77 when the Robert Wood Johnson Student Aid Program was terminated, although it still maintains some loan funds under the United Student Aid Funds.

The alternatives which remain for low income students who manage to gain admission to the professional schools include the service-obligated scholarships—the NHSC and Armed Forces programs—and the Exceptional Financial Need award, for first year students only. There are the several loan programs administered by the Office of Education (HEAL, GSL, NDSL) and the much diminished Health Professions Student Loan program, as well as limited school and private support. Except for the very wealthy, almost all students will graduate with either service obligations in a shortage area or large accumulated debts of college and professional education. While the former addresses the geographic distribution problem temporarily, scholarships do not guarantee continuous care to underserved areas and commit lengthy and expensive support to both the student and National Health Service Corps (NHSC) practitioner in the field. Those most likely to stay in the shortage areas beyond their obliga-
Special Interest Admissions

On occasion university presidents, deans, and other top academics do make "special interest admissions" outside normal admissions procedures and standards. . . . "Benefit" to the school is said to be the controlling factor in such admissions.

The national media in the last 2 years have carried reports indicating that professional school admissions have, in some cases, been viewed as a means of maintaining good relations with influential or well-to-do individuals who are in a position to assist university appropriations or endowment funds.

Most recently news accounts have focused on remarks of the president of Boston University during a 1973 school committee meeting. A transcript quotes President John R. Silber as having said:

"We need, for example, a list of admissions considerations that we've given. There have been any number of people crawling all over me for admission to our Medical School and our Law School who have never been tapped systematically for a gift to this university. I'm not ashamed to sell those indulgences. We don't admit someone to our Medical School or our Law School who isn't qualified to get in, but at the same time when we facilitate that admission there's no reason why we shouldn't go right back to the person, the father of the person who's been admitted and talk to him about a major gift to the school. We have not done this systematically."

At the University of California at Davis, the dean of the medical school, in several instances reported in the Los Angeles Times, intervened in the admissions process "to correct injustices in the admissions procedures and for public relations reasons."

In October 1975, New Physician magazine reported that school records indicated that the Chicago Medical School had in 1973 favored 77 out of 91 qualified applicants on whose behalf pledges of financial support were made to the institution over other applicants otherwise equally qualified.

Most recently, NBC television's "Weekend" program reported on illegal and questionable admissions procedures in the State of Pennsylvania. The U.S. Attorney for the Eastern District of Pennsylvania charged:

"These schools live and die by what happens in Harrisburg [the State capital], and I think that's why the legislators and the politicians have this kind of hammer over the schools. It is pretty clear, the word on the street is you have to pay off somebody to get into medical school."

"It is extremely pervasive, far more pervasive than we thought when the investigation started."

Legislative pressure on the medical school admissions process in Pennsylvania appears to be a matter of routine, according to one academic official. Dean Joseph DiPalma of Hahnemann Medical College in Philadelphia explained on the same "Weekend" program:

"I would say of all the applications we have, more than half of them will have a letter from a legislator . . . and certainly when any politician recommends a candidate, and does so very strongly, I would be foolish to say that I didn't try to listen and I didn't try to do everything possible that I could. Let's say there's an instance where there's two applicants for admissions, and one of these applicants is favored by a prominent politician, well naturally you'll take the one who's favored since the world works by doing favors . . . ."

—United States Commission on Civil Rights
June 1978
The commercial student loan market

This is not without design. As the numbers and size of this loan market grows, it has been privatized, with federal government assuming the financial risks. As can be seen quite dramatically, while the federal Health Professions Loans and Scholarships are being phased out, the private Guaranteed Student Loans have skyrocketed. (Figure 6). In 1970 Guaranteed Student Loans accounted for about one-quarter of all loans to medical students, but by 1977 it accounted for almost 60 percent. The GSL program was initiated in 1965 to subsidize and insure commercial borrowing.

The American Bankers Association (ABA) clearly indicated in a 1975 report that its members were reluctant to make guaranteed loans because of the low interest rates, which were almost two percent below the prevailing market rate. Although the guarantees provide some advantage by eliminating the risks of default, the ABA complained that the various guarantors were slow to refund on defaults (which were increasing rapidly in number), that the Office of Education was inconsistent in pursuing defaulters, and that the frequent changes in federal regulations created constant administrative problems. A second survey in 1975 by the Office of Education found that the banks' major objections to the loan programs were their low income and long repayment periods, which during inflationary periods further subsidized the borrower. That study found that, without substantial changes in the program, less than 30 percent of the lending banks planned to increase their GSL holdings, and most of these were smaller banks.

To put it simply, the banks had told the federal government that without more profit, they would not participate in the program. Congress responded by giving them what they wanted. To support the banks, the Student Loan Marketing Association (SLMA or "Sallie Mae") had been created in 1972. It is a federally-chartered, private corporation which purchases large blocks of student notes from lenders with money borrowed at favorable interest rates from the Federal Financing Bank. The cash which Sallie Mae provides the lender is then reloaned at four percent above its cost or "leveraged" by repeated borrowing from Sallie Mae at 80 percent of the face value of the student loans, multiplying the lender's original capital severalfold, resulting in dramatic rates of return—easily as much as 24 percent on an original $100,000 investment, according to former HEW Secretary Joseph Califano (36). Sallie Mae, originally designed to attract private capital for student loans, is now 98 percent public capital and deals with only about 100 of the largest of the 8,500 lenders in the GSL program!

This was not enough, as the 1975 ABA report clearly indicated. To spread the profits around to all its members, the ABA still wanted higher interest rates. So, the Tax Reform Act of 1976 was passed, permitting non-profit organizations to purchase the guaranteed loans by issuing tax-exempt bonds. The interest rate of the guaranteed loans were raised to 12 percent—7 percent paid by the student and 5 percent by the federal government. What's more, the recently created Health Education Assistance Loan program surpassed the market with a 12 percent interest rate plus an additional 2 percent insurance premium, for a total allowed interest rate of 14 percent!

As the commercial interest rates began to soar, former Secretary Califano moved to cut federal contributions to these programs and to cut off loans to Americans studying in foreign medical schools. While the student pays 7 percent interest on a Guaranteed Student Loan, the federal government must pay this to the banks while the student is still in school, as well as the additional 5 percent "allowance" during the life of the loan. The federal government also absorbs the costs of defaults and many collections. Califano's proposed "federal bank" would eliminate the additional costs paid to support the banks' commercial rates. His proposal echoes the AAMC's 1970 recommendations.

Charles W.V. Meares, Chairman of the Board of United Student Aid Funds, Inc., supported by the Robert Wood Johnson Foundation, objected, calling the current subsidy program "a happy combination of Government and private-sector activity" and cited the growing participation of lenders. He challenged Califano's implication that private lenders are reaping considerable profits from student loans, noting that the subsidized interest rate of 12 percent is very near the going market rate (37). If this is true for the Guaranteed Student Loan program at 12 percent, the HEAL's 14 percent rate promises quite a windfall for the private lenders. Both will continue the public subsidy of the largest banks "leveraging" with Sallie Mae.

Medical school costs

Over the last decade total expenses have risen far more quickly than loans or scholarships, so...
increasing amounts must be paid from student and family resources (Figures 6 and 7). To compound this, the numbers of students who must share these resources have increased, while the Exceptional Financial Need, Armed Forces, and National Health Service Corps (NHSC) programs concentrate the total available support among a smaller number of students, only 1.2, 3.6, and 6.6 percent of this year's entering class, respectively. Since the Armed Forces and NHSC scholarships are not awarded according to need, they exacerbate the already class-related financial support that actually provides subsidies to the more wealthy, whose tuitions at more expensive private schools are thereby paid from the public purse. In the name of equitably distributing the service obligations, the class inequities continue to be served, just as they were when the non-disadvantaged benefitted from the poor and erratic administration of the Health Professions aid. Only the private National Medical Fellowship program, aimed specifically at minority students, has consistently followed "need-based" distribution and as a result distributes most of its money to low income students (Table 5). At the beginning of the AAMC affirmative action program in Academic Year 1971, 60 percent of students with family incomes less than $10,000 received federal scholarships and 90 percent loans; by Academic Year 1974–75 when minority admissions peaked, this had already declined to 24 and 46 percent, respectively (27). More than half of Black and almost half of Hispanic and Native American medical students came from these low income families in 1974–75 (17).

The medical schools blamed Congress for this squeeze upon the disadvantaged. But they were, in fact, those who since 1963 administered the federal assistance disproportionately to the advantaged, in part because the disadvantaged were not admitted in the first place. Under the banner of academic freedom they mobilized the powerful lobbying effort through the AAMC that prevented Congress from imposing meaningful quotas for primary care training, for students committed to service in shortage areas, and for American transfers from foreign medical schools, and from significantly cutting capitation grants. However when it came to major cuts in affirmative action programs and to development of regressive financial aid formulas, somehow, they want the public to believe, they lost their political clout.

In the absence of strong outside influences, such as the civil rights movement, the self-interest of health professional institutions is not served by vigorously defending progressive, need-based financial aid or need-based admissions (i.e., serving the needs of the nation rather than the profession and the schools). Admissions to the health professional schools since Flexner have largely replicated the existing hierarchy in the society, in the profession, and, particularly, in the schools themselves. (See Part II of this article.) During the past decades’ expansion of the health professional schools’ enrollments and funding, additional places and financial aid dollars were given to women and minorities without losing a single white seat and without significant re-allocation of resources or places to the disadvantaged.

Women and minorities might bring, given sufficient numbers, a set of values and priorities which would challenge the business-as-usual conduct of the academic health centers. They might challenge the way in which “their people” receive care from academic training institutions, the models for the profession, and the manner in which medicine and the other health professions function as a social control and policing agent upon women, minorities, and the poor. They might also challenge the ideology which serves the needs of the status quo and capital, turning social and political problems, like stress, malnutrition, and occupational health, into medical ones.

Quite predictably, after the pressure of the civil rights movement waned and fiscal austerity and lowered expectations took its place, the academic health establishment has regressed in its admissions policies. The Bakke case has merely diverted attention from the responsibility and complicity of academic institutions in draining the affirmative action movement of its momentum and funding. Meanwhile, investments are secured, federal support curtailed, and health professional education returns to business-as-usual. Equal opportunity will remain a mirage as long as opportunities are sold on the marketplace to the highest bidder.

— Hal Strelnick

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Off To a Bad Start

Both the objective and subjective experience of childbirth have changed dramatically for many middle class women in the last decade. The purpose of this article is to examine the subjective reality of a very different group of women—low income, mainly Hispanic women in East Harlem. It focuses on the use of obstetrical services, the relationship between health-seeking behaviors and knowledge, information and beliefs about the childbirth experience and the impact of the institutional setting on the prenatal, intrapartum and postpartum experiences of low-income, Hispanic women.

East Harlem is a low-income residential community of approximately 135,000 people in New York City. The bulk of the population currently consists of migrants, mainly Black (35 percent) and Puerto Rican (48 percent), and white ethnics (17 percent), mainly Italian. The median East Harlem family income in 1972 was $5,895, and the families earning less than $5,000 per year were almost double that for all of New York City. One out of every three families in East Harlem is below the poverty level. Public assistance is a common reality in this community, with 44 percent of the population dependent upon it for survival.

Women in East Harlem between the ages of fifteen and forty-four comprise almost 30 percent of the total population of women. Data show that women in East Harlem have more children than women elsewhere, at a younger age, and more frequently without being married. In 1970 the rate of live births per 1,000 females in New York City was 81.5, in Manhattan 65.5, and in East Harlem 82.9. Among the Puerto Rican women in East Harlem, this rate jumped to 96.6. The percentage of births out of wedlock were significantly higher in East Harlem (52.1 percent) than in Manhattan (37.3 percent) in 1976. Although recent data shows infant mortality to be declining in all areas of the city, the infant mortality rate of 23.5 death per 1,000 live births in East Harlem remains quite high compared to that of 19.3 in New York City. In 1976, 12.1 percent of births in East Harlem were premature or low birth weight (less than 2,501 grams) compared with 9.5 percent citywide.
In spite of a multitude of health service facilities in East Harlem, very little is known about the particular health needs of Hispanic women and their families, or their use of services. A 1970 household survey conducted by Johnson (1) in East Harlem was a first step toward answering these questions. The results clearly showed that health was a high priority among Hispanic women in East Harlem, and that they perceived their health to be worse than either blacks or whites in the area. Our study, reported here, was intended to explore in more depth some issues raised by that study.

**Study Methods and Sample Population**

The nature of our inquiry was exploratory. It was geared to examine two major areas: the nature of the intrapartum experience; and the attitudes and expectations of our sample populations toward the birth experience. Two major methods were used to explore these areas: one was an extensive open-ended questionnaire which was administered to 26 women who came to the pediatric or family planning clinics of the neighborhood health center; the other was an open-ended interview conducted with personnel of the community-based neighborhood health center. In addition, unpublished reports and studies conducted at the neighborhood health center were also used.

All of the women interviewed were of childbearing age and all had given birth to at least one, and usually more children. Most were Hispanic (nineteen), predominantly Puerto Rican, and the remaining seven were Black American. The majority of the women had spaced their children two or more years apart, and for those women who had more than two children the spacing was usually four or more years, with some of the women over thirty years of age having had seven to eleven years spacing between children. The majority of women were on Medicaid, with only a few on the Medicaid fee scale that indicated some working income for the family. Of the eight women who worked outside the home, most were in paraprofessional occupations based in the community, such as teacher's aide, community worker, and community health workers.

**Utilization of Obstetrical Services**

The municipal hospital and the university teaching hospital were the most frequently used facilities in East Harlem. Over half of the women interviewed used both these facilities during any given time period. Although the neighborhood health center was used on a continuous basis for pediatric care, the two hospitals were used for emergency, routine or particularly acute problems of the women themselves, as well as for emergency pediatric problems that occurred when the neighborhood health center was closed. The greatest number of women used the municipal hospital clinic connected to the obstetrical service of another teaching hospital (now closed) for prenatal care. It also provided food coupons under the Maternal-Infant Care (MIC) program. Three women used the Harlem Hospital Clinic in Central Harlem; the remainder used other hospital facilities or private physicians. Decisions to use facilities were not made arbitrarily, but were based on both previous experience and on recommendations of informal networks of friends and relatives, particularly mothers.

In seeking obstetrical care, the women were very much aware of the attitudes of hospital staff—both nurses and doctors. They usually obtained such information by asking others or from their own previous experience. Many women described instances of being ignored or of being "cursed out" by the doctor for screaming while in labor. In one instance, an adolescent who gave birth at a municipal hospital described her interaction with staff during labor: "The nurses encouraged me to keep my baby. They stated, 'If you enjoyed making it, keep it.' Later when the doctor was examining her, he stated, 'This isn't going to hurt you any more than when you were doing it.'"

Such experiences partially determined the women's own use of facilities; they also provided the basis for recommendations to others. Their use as criteria, however, also reflected the respondents' limited sense of control. The women specifically described as bad experiences verbal abuse from medical staff. They usually did not generalize these specific instances of abuse to the institution as a whole, however, unless abuse was widespread and continual, as appeared to be the case.

*Within the area there are four hospitals, five child health stations, four methadone treatment centers, four halfway houses for drug addicts, six school dental clinics, two nursing homes, a District Health Center, and a community-based neighborhood health center, which opened in June 1975. Few private physicians practice in East Harlem. "Medicaid mills," however, abound, with roughly twenty operating at any one time.

**The limitations of our methodology included pro-NHC respondent bias because the interviews were conducted on-site and self-selection problems generated by choosing women who were registered at and users of a primary care center.
for example, of the nursing staff at the local municipal hospital.

In general, however, the women rarely claimed to have had degrading experiences, although they described incidents such as no medication during childbirth when requested, frequent examination by several "doctors" (probably medical students) and sexist remarks by physicians or snide comments by nurses which made the patient uncomfortable. Although the patients did not perceive these as bad or particularly disturbing experiences, perhaps because they were irregular, they nevertheless appeared to take precautions to avoid further use of that facility. The large numbers of students participating in the internal examinations of laboring women, comprised one of the few consistent complaints. One young woman became so accustomed to examinations by different doctors-in-training that it took her a number of nocturnal visits to realize that the man who woke her up in the middle of each night to give her an internal while she was in the hospital for a tubal infection was sexually assaulting her.

Except for cases of extreme abuse or obvious medical negligence, however, the women in our sample, like most poor women, took their object status for granted. Their responses were congruent with the generalization that the poor pay for their penury with their privacy, often with their dignity, and not infrequently with their health and that of their family. These women in East Harlem did not consider that their privacy or dignity was rightfully part of their patient status. Thus they frequently made decisions based on their perception of the facility's technical expertise as it applied to their physical health and that of their infants, rather than upon the actual quality of care received.

**Knowledge, Information and Beliefs**

Culturally these women are prepared for a very negative and unfulfilling obstetrical experience, and this expectation is reinforced by the health care providers they encounter. The birth experience for these women is not a "joyful" nor pleasant one. This can be attributed to several factors:

Primarily the cultural ethos has identified the birth experience as a painful one which the woman must undergo alone. Oftentimes the result is a state of fear and virtual hysteria. The close association of pain with childbirth is rooted in the fairly recent history of Puerto Ricans who are mainly from rural and/or agricultural communities where women frequently delivered their own children under adverse conditions, often without the help of trained personnel. Many of the mothers and grandmothers of these women have described horror tales which are reinforced by being passed down for generations and which, no doubt, have become grossly exaggerated.

Coupled with this is the fact that men, be they fathers, husbands or male birth attendants, have not traditionally played a significant role in the birth experience due to stratification of roles in traditional rural Hispanic society. Childbirth has been perceived as a woman's function, and the person who usually provides both the support and the "fears" is the mother of the woman. Thus the culture expects women to express pain during labor and delivery. This reaction is antithetical to the current providers of health care, however. The fear suffered by these women may make them tense, which makes childbirth even more difficult.

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**In obstetrical practice, it is no recent phenomenon that patient race, ethnicity, class and institutional exigencies are the strongest determinants of what technologies are employed during childbirth**

Many of these cultural attitudes are integral to the belief systems of these women. They expected the birth experience to be unbearably painful; they did not expect, and in many instances did not want, their male partners to participate in the birth experience, and often sought help or solace instead from their mothers during labor and delivery. In some instances they were accompanied to the hospital by the husband or a relative of the husband or the mother. One woman did want her husband to join her in the labor room; he was not allowed, in this case, because he had not taken childbirth classes. In the majority of cases, however, the patients' choice was to have the baby alone.

Because the sample population perceived the birth experience as a negative one, very few women attended childbirth classes. Unless these were specially designed to be bicultural and bilingual (2), childbirth classes often conflicted with the realities of everyday living of these respondents. The main reference group for these women was their immediate families and friends, whose negative view of the birth experience would be more influential in "preparing" them for the birth experience than would the teaching of nonrelatives. As one woman stated when asked about childbirth classes, "I am chicken and am not
interested in childbirth classes because I don’t want natural childbirth.” This attitude was relatively common among the women interviewed.

In some instances the failure of the women interviewed to demand or take advantage of different options in childbirth experience may have been related more to the woman’s perception of her own lack of resources than to objective conditions. When questioned about feeding practices, many women interviewed in East Harlem, for example, said that they decided not to breastfeed because they thought they had to eat well in order for their breast milk to be healthy for their babies, and they did not feel they could afford such nutritious eating habits. These women also tended to reject natural childbirth classes because they could not count on a support person to be present for classes, and for labor and delivery. Most saw childbirth as an ordeal to be suffered through, and they did not feel they could afford such supportive experiences which reinforce the passive conception of childbirth as a family-oriented experience.

As a result of cultural and systematic barriers to childbirth education, most of the women had not been prepared for the birth experience and were uninformed about birth procedures. Although the women interviewed mentioned having several complications, such as high blood pressure, and water retention and swelling (preeclampsia), they did not understand the implications. Whether this lack of knowledge was due to communication barriers, cultural inhibitions regarding the discussion of sexuality and/or the negative attitudes of health care providers is difficult to determine. Possibly a combination of all three factors fostered the unpreparedness of these women for the birth experience. The data suggests that women with little education and less money often feel that, as wards of the health care system, they must be unquestioning recipients of its services.

Several women mentioned wanting “something to kill the pain” during labor, but not asking for it. This passivity led women to not question various procedures such as fetal monitoring even though the laboring mother felt permission should have been requested. This passive response is to some extent learned behavior. A number of women described situations in which they had responded actively only to be threatened (“cursed out”) or ignored. One woman, in labor with her first child, said she didn’t know anything and was screaming. Her doctors kept “cursing” at her, threatening to leave her unless she kept quiet.

Another respondent who repeatedly questioned a report of abnormal cells on her pap smear said no one would explain the meaning of “abnormal.” “I got the feeling that I should stop bugging them.” She then described problems in understanding directions and obtaining medical follow-up that reflected an indirect and self-destructive response. While her attitude toward her health providers became overtly passive, her non-compliance denoted active resistance to a forced dependency. Among low-income women, repeated experiences which reinforce the passive patient role, the lack of exposure and familiarity with the advantages of alternatives in obstetrical care and a lack of a personal gatekeeper (private physician) all contribute to a pattern of care in which the woman has no active role. Options, even when formally available, are meaningless within an institutional setting which sees no participatory role for these women.

Prenatal, Intrapartum and Postpartum Institutional Experience

The women in East Harlem sought and received prenatal care on a regular basis, most (15) beginning prenatal care during the first trimester. The most frequently occurring problems during pregnancy, each affecting more than half of the women interviewed, were water retention, swelling and high weight gain. The majority of women received anesthesia during labor. Fourteen had requested anesthesia and ten had not. A number of women expressed not understanding why they were given anesthesia during labor. Of those women who requested anesthesia, only one was given a choice as to the type of anesthesia desired, and she was, at the time, a private patient in a private hospital. The majority of women received injections upon entering the labor room without explanations or queries as to whether they wanted the anesthesia. These women reported that they felt “sleepy;” other women reported that they weren’t aware of being given medication but did not remember the experience and “felt dizzy.” Several women reported having their arms and legs bound to their beds during labor and/or delivery: “They scared me because they put all these machines around you and strapped you.” Another stated, “They threw you on a table as if you were a piece of meat. They put rubber on your legs.”

Many women who were “forced to deliver naturally” received injections or gas after the delivery of the child. Close to half of the respondents said that they had asked for anesthesia but their requests were denied. One woman describes this experience: “It was my first baby and I wasn’t used to it. I carried on terrible and had fits. I had asked the doctor for something during labor but...”
The majority of women received injections of an anesthetic upon entering the room without explanations or queries. Several women reported having their arms and legs bound to the beds during labor and/or delivery.

The doctor never came back with anything. I guess that they wanted me to have my baby on my own. I was given gas during delivery.

Two approaches to pain-relief are used by the obstetrical system for low-income minority women. Either anesthesia is administered as soon as the woman enters the labor room in order to deliver the child for her without her participation or interference; or, labor is induced or hastened by chemical stimulation upon arrival in the hospital, the woman is "forced to deliver naturally" and then, anesthesia is administered in the last stages of delivery or after delivery. The health care providers frequently expressed the sentiment that no painkillers should be given to these women either because the women "deserved" the pain—a reference to their alleged promiscuity—or because of their reported exaggeration of and inability to tolerate pain.

Medical intervention—such as the use of anesthetic, analgesic, forceps—and induction and stimulation—was frequent enough among this sample population that women who had given birth previously understood that the earlier they entered the hospital during labor, the more likely they were to undergo invasive and unwanted intervention. Thus many of these women reported during the interview that for subsequent children they preferred to wait at home or go to relatives’ house until they “thought they were ready to deliver,” in order to avoid intervention at the hospital. One 36-year-old woman describes her "technique": "For the first baby, they gave me a spinal and used forceps. For the other three children, I waited until the last minute, and then went in and there was no time for anything."

A substantial number of women, however, reported being “drowsy” after birth or having been “knocked out” after the birth experience. As one woman described, “They let me suffer it out until the end. Then I had a ‘convulsion’ and was knocked out with gas.” She stated that she was shown the baby, but she told them to “take it away because the baby had caused so much pain.” Some women reported postpartum complications such as fevers and vaginal infections which prevented them from holding their child. Only three of the twenty-six women held any of their babies immediately after birth. Although the majority of women (22) were shown their baby, six women reported waiting a period of one to three days prior to actually holding the infant. Infant birth weights averaged 6 pounds, 8 ounces. The average hospital stay for the mother was 5.10 days; infants stayed an average of 6.8 days. These rates may indicate a high rate of maternal and infant complications and morbidity.

Two women breastfed their children. The most frequent reasons given for not breastfeeding were that it was inconvenient, it required better eating habits than the women could afford, the women were disinterested or they did not have enough milk. It is also clear that the vast majority of the women were not informed of the advantages of breastfeeding, and/or encouraged to breastfeed by the physicians or nurses. One 36-year-old woman said about her fourth and last infant, “I couldn’t breastfeed because my glucose tolerance test showed some diabetes.” Another woman, 32, with a 22-month-old child, stated that she had tried breastfeeding, “but it was too painful.” Recent findings indicate that although increased information and advice caused more women to consider breastfeeding, it has no effect on the ultimate choice of whether to breastfeed or not. Women receiving advice and information regarding breastfeeding from grandmothers or other significant female figures are more likely to give it full consideration than those who were informed or advised by medical personnel, but were still unlikely to change their behavior.

While breastfeeding has been related to postpartum mother-infant bonding, these women did not know about the importance of the bonding experience and passively acquiesced to the institutional practice of separating mother and infant. The majority of women did not hold their baby until several hours after the birth, and a few not for several days after birth. The women did not question this experience unless, after a few days, they feared the baby was ill or that information about their child was being kept from them.

Recent demands for changes in obstetrical services stem largely from the middle class. Thus childbirth education, birth-room or labor-room deliveries, unmedicated labor and delivery, father and sibling presence, family bonding, breastfeeding and rooming-in options are increasing among private patients but are slower to spread to the lower classes. The women interviewed fre-
Many women who were 'forced to deliver naturally' received injections or gas after the delivery of the child. Close to half said that they had asked for anesthesia but their requests were denied. Frequently did not know these options existed. If they did know of the options, these women were uninformed or misinformed of their value. Even if they understood and accepted the value of the options, they were unable, or believed they were unable, given the structure of ward care, to exercise them. A local teaching hospital, for example, has a pediatrics department adamantly opposed to allowing a bonding period between mother (and father) and infant. With the help of her obstetrician the private patient can generally circumvent this rule. The clinic patient, however, is more likely to be "delivered" by a resident or staff physician who has little stake in defying another department for the sake of a family he or she will never see again.

Although the descriptions of those women's birth experiences would be judged by many today as negative (4), our respondents had no expectation of meaningfully altering the experience of birth. Here again they accepted themselves as passive recipients of a process over which they had little understanding, and no control.

Summary and Conclusion

Among Hispanic women in East Harlem the birth experience is determined by four forces. First, and probably strongest, are the institutional requirements spelled out in terms of procedures, public and private services, resident, staff and attending needs, training and practice exigencies, research requirements and conformity to professional norms of practice, often in contradiction to most recent scientific findings* (5).

Second, and reinforcing that pressure, is the tendency of women patients, and particularly poor women, to accept a passive role in medical care, and to become classic dependent patients, bowing to the force of medical expertise and professionalism.

Third, cultural attitudes and norms passed down by generations of Hispanic women, although they stress family ties at home, tend to characterize the birth process as a painful and frightening experience to be faced in isolation. Spiritual and superstitious beliefs that foster ambivalent feelings toward the husband during pregnancy reinforce these expectations (2).

Finally, the generally low health status of poor populations tends to result in a number of health problems in pregnancy; these become high risk factors leading to aggressive medical management and control. These four forces work together to foster patient passivity and promote provider-controlled childbirth.

In obstetrical practice, particularly in the United States, it is no recent phenomenon that patient race, ethnicity, class and institutional exigencies are the strongest determinants of technologies employed during childbirth. "Twilight Sleep," for example, was not uniformly safe or available when it was first demanded by upper and middle class women in early Twentieth Century, and many physicians opposed it violently (6). There were, however, major advantages to the medical profession of using general anesthesia and/or amnesiacs. Specifically, their use increased the need for in-hospital births as well as the potential for complete physician control of the birthing woman during labor and delivery. Such control meant that other procedures, such as the use of forceps and episiotomies, could be managed easily and routinely. In fact, women were often classified in terms of their probable cooperativeness, and those who appeared to be potentially difficult patients were placed in the higher medication category (7).

Just as today certain types of pain-killing medications are more likely to be given to middle-class women than lower-class women (especially epidural anesthesia—a spinal anesthesia which allows a woman having a vaginal or even cesarian delivery to be awake and aware but desensitized to pain), certain obstetrical procedures are more common among the middle-class than the lower class, regardless of increased risk often faced by lower-class women because of their poorer health status. A recent British book on obstetrical practices in the U.K. and the U.S. (8) underscores this phenomenon:

"Social differentials account for much of the increased mortality in the lower social classes, yet, ... an inverse law operates in obstetrical services. Variations in the use of intervention suggest that techniques such as induction, cesarian section and forceps delivery are too little employed for maximal effectiveness in lower-class populations. ... Middle-class women are not only more
likely to get what they want but, through pressure groups, will work for services most related to their sexual needs. Because of shared assumptions and knowledge, middle-class women are most able to communicate their symptoms, feelings and wishes in encounters with professionals. Working-class women, by contrast, are frequently seen to be inarticulate by professionals, and discussions of possible strategies of treatment is regarded as a waste of time" (p. 162).

Medical practitioners have learned from practicing on, teaching from and experimenting on poor women, but the women themselves have only belatedly reaped the benefits

Similarly, examination of New York City birth records have shown that among low-risk New York City pregnant women who are private patients, white and who seek early prenatal care, there is a higher rate of labor and delivery interventions that among pregnant women who are general service (clinic patients), non-white and who start prenatal care late in their pregnancies. On-going research appears to confirm and strengthen evidence of this class difference, showing that induction, stimulation and cesarean section rates all clearly vary directly with social class (9). Whether middle-class women receive more medical intervention because private physicians use more skill, care and attention, or because those who pay for more medical care receive more medical care regardless of health need, is unclear. The class basis of obstetrical practice, however, seems amply clear.

Medical practitioners have learned from practicing on, teaching from and experimenting on poor women, but the women themselves have only belatedly reaped the benefits of medical advances. The social control model of service delivery in the United States (10), in combination with the pressures of fee-for-service medicine, has meant that the obstetrical experience of poor women tends to be dominated by considerations of institutional and professional exigency. Middle-class demands on obstetrical practice are likely to be translated into services for the lower-class only if and when they expedite services or reduce costs or if and when the gap between public and private care becomes so large as to evoke public and political criticism.

Aside from the possibility that poor women are poorly served medically under these conditions, there is a probability that they and their families are actually injured emotionally. The hospital intensifies the mother's already fearful and disease-oriented attitude toward childbirth, and then cements that attitude by separating mother and infant immediately after birth. The unhealthy state of mother and child is assumed, and the mother's feeling of alienation from the birth process and product is enhanced. Given current practices, the important transfer of knowledge from infant to mother during the first hours of life and the immediate development of maternal attachment feelings and attitudes (11, 12, 13) is least likely among poor, minority women in urban America than any other group. Yet, given the difficulties and demands of the life outside the hospital to which these women must return, it is even more important.

Alice Rossi's recent description of childbirth (14) fits all too well the poor Hispanic woman, frequently stereotyped by providers for her high rates of mental illness and psychosomatic complaints: "...we interfere with the natural process through medical distortion of spontaneous birth; separate the mother from the neonate for most of the critical first days of life; feed babies on a rigid hospital schedule and keep them in a brightly lit and noisy nursery; and then we send the mother and child home to an isolated setting to cope as well as she can on her own. ...If she breaks down under this strange regimen, we define her as incompetent in handling 'normal' female functions."

—Ruth E. Zambrana, Ph.D. is a sociologist in the Department of Community Medicine, Mt. Sinai School of Medicine, New York, and Marsha Hurst, Ph.D. teaches in the Government Department of John Jay College of Criminal Justice (CUNY), New York.

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'Murdochian Sensationalism?'

Dear Health/PAC Bulletin:

We were extremely distressed to read the bold print insert above the second page of our column on electronic fetal monitoring in the triple issue. It is not, unfortunately, simply a Murdochian sensationalization of the content of our article, but is a contradiction of what we have written. On these pages we argue that although proponents of electronic fetal monitoring point to the recent decline in infant mortality as proof of the effectiveness of this diagnostic technique, there is no evidence that there is any causal relationship between increased use of EFM and decreased infant mortality rates. The boldfaced blurb completely turns around this critical point by asserting that the relationship between EFM and lower infant mortality is indeed true, and implying that the EFM debate is thus one of weighing mortality risk of the infant against mortality risk of the mother. A lesser distortion occurs in the second sentence of the blurb where the editors have listed a number of primary and secondary, direct and indirect, likely and unlikely, serious and non-serious complications related to the use of EFM, without, of course, saying or implying any distinction.

We trust that the editors will not only publish this letter by way of correction, but will take pains to avoid this type of distortion in the future lest otherwise enthusiastic supporters will be discouraged from contributing to or reading the Bulletin.

Sincerely yours,
Marsha Hurst, Ph.D.
Pamela Summey, M.A.

Human Sciences Press
72 Fifth Avenue
New York, N.Y. 10011