

REMEMBER THE DIGNITY
OF YOUR WOMANHOOD.
DO NOT APPEAL,
DO NOT BEG,
DO NOT GROVEL.
TAKE COURAGE,
JOIN HANDS
STAND BESIDE US.
FIGHT WITH US....*

CHRISTABEL PANKHURST
ENGLISH SUFFRAGETTE, (1880-1958)



April 4-7, 1975
Boston, Mass.

PROCEEDINGS

for the

1975 CONFERENCE ON WOMEN AND HEALTH

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There is no fee for registration or films. Much of the literature on display in the conference resource center is free to registered participants. Conference book shops have been set up by the Black Survival Bookstore, the Red Book, New Words and Other Voices.

Day care services for children under five are also free to registered participants. The conference day care center is located at Simmons College.

Children cannot accompany adults to any workshop or panel held in the following rooms:

Courtway Aud.	Minor Room
Ware Room	Allen Room

The following events were added to the Conference:

- Survival Houses for Women
 - Kip Tueran
 - Rape Victims, Women in Prison and Prisoners Against Rape
 - Boston Area Rape Crisis Center
 - Ball Fund
 - Feminist Alliance Against Rape/Prisoners Against Rape
 - Nurses and Medical Students
- Prostitution
 - Boston Area Rape Crisis Center
 - Women in Prison
 - Evaluating Health Care and Planning Referral Services
 - Pam Booth
 - Rachel Fruchter

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Association for Childbirth at Home
American Medical Women's Association, New England Chapter
Boston Area Rape Crisis Center
Boston Women's Health Book Collective
FOCUS: Counseling & Consultation
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Harvard Medical Area Women Students Association
Health Coalition of Third World Women
Health Task Force, Gov's Commission on the Status of Women
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Women students, U Mass School of Nursing
Women's Community Health Center, Cambridge
Women's Therapy Group, Homophobic Community Health Service

Photograph by Vicki Laurence



April 5, 1975

History Of Abortion Laws In The United States

By Dorothy Brown, M.D.

Interest in the subject of abortion laws, on my part, emanates from three (3) outstanding factors which I shall enumerate with frankness and sincerity at the outset of this presentation:

- I. Undue pressures in my role as a woman physician and surgeon who has a sincere interest in the ethical as well as the honest conduct of a medical practice.
- II. The pressures of changing world and national opinions about the rights of women in a Democratic society.
- III. The accuracy and justice of the individual's rights to determine his or her own basic morality, with or without religious precept, and the individual and parallel responsibility for abortions from the basic moral code which governs this Democratic society.

These three (3) factors among others, made it easy for me to take advantage of an opportunity to seek election to the lower house of the Tennessee State Legislature in 1966. I was successful and did serve in the 85th General Assembly of the Tennessee State Legislature.

I immediately set to work as a Freshman Physician-Legislator and authored a bill to revise and to update Tennessee's archaic Abortion Statute passed and enacted in 1883, realizing that this action had to take place at the state legislative level because there was no *judicial* anti-abortion law at that time.

In addition, I was thoroughly convinced of the fact that whenever the laws that govern the collective actions of people lose their accuracy, and their political or social expedience, then such laws should either be revised or repealed—for the books of statutes from state to state across this nation are replete to the point of disgust and social and legal embarrassment with laws that are archaic and no longer germane to the original purpose for which they were enacted.

My action in this regard stirred an emotional and moral "tempest in a teapot" in the state of Tennessee deep in the so-called "Bible belt" of the nation. I was asked to take my bill out of the hopper and was forthwith warned that if I did not "cease and desist," that this would be my first and last tour in the legislature. But, I was committed and determined to see this matter through to its bitter end. I did just that, and, true to fact, it was indeed my first and last tour in the Legislature—I have not made a successful "run" since—apparently I raised enough legislative "Hell" that "one time around." However, it is of interest to note that the state of Tennessee still has on its book of statutes a law which states that sexual intercourse between unwed adults is a crime punishable by up to one year in jail. In 1977 such a case (Hester & Jenkins vs. State of Tennessee) resulted in a fine of \$250.00 and a work house sentence of 11 months and 29 days—this ruling could not be overturned by the Tennessee Court of Appeals because the law was plainly written.

The more I studied, researched, and inquired as I prepared the legislative brief of defense for this proposed bill, the more thoroughly convinced I was of the fact that no discussion of this bill was either rational or feasible without a presentation of the history of abortion legislation in this nation. It is interesting to note that prior to the 19th century, there was no statutory Abortion Law in any country of the world, including the United States. The first such law enacted was in Great Britain in 1803. Then in the United States the first law was passed in the state of Connecticut in 1821. The legislative brief presented for the passage of this law stated, in essence, that the law was needed to "save the lives of mothers." Prior to this date, no state had an abortion law nor did any state have:

- antibiotics
- lockjaw antiserum
- sterile or aseptic surgery
- the mechanics for the administration of blood transfusions.

An abortion at that time was a medical procedure agreed upon by a woman and her physician; it was also a medical procedure which, when done either in the hospitals or clinics of that early date, was fraught with an extremely high mortality rate. These women died of "puerperal" sepsis, lockjaw and blood loss, so much so that women were said to be "dying like flies."

The level of the art and practice of medicine and surgery in the 1820s was so rudimentary and unscientific that it is astounding now to review pictures of physicians and surgeons at work and to note that they were dressed and ready for surgery "decked out" in their Sunday best black frock-tailed coat, grey pin-striped pants, white wing-tipped collar and black bow tie. They were further shown just simply washing their hands at a basin and then drying their hands on a common towel laying across the edge of the basin—the physician was then ready for surgery or the delivery of a newborn! Is it any small wonder, then, that women were dying "like flies" and, therefore, needed the protection of a law to reduce the number of deaths due specifically to abortion procedures!

So, the laws were passed and it is of critical note at this point to remind the people of this audience of the fact that every state in succession had as its legislative intent in passing their abortion law that its enactment was to save the lives of mothers and that there was absolutely no legislative concern for the developing fetus.

There was no legislative concern for the developing fetus because the church had made an adequate disposition of this problem—for it was the thinking of the church at this point in time, that the developing fetus was without soul until the 4th or 5th month. For eight centuries, the church (collectively) had held that the soul was infused into the developing fetus at the time of "quickening," this being that time in the 4th or 5th month when the woman felt the developing fetus move within her for the first time. This event was termed infusion of the soul by indirect or delayed animation. Great religious writers and theologians like the Spanish Jesuit priest, Thomas Sanchez, of the early 16th century and the great moral theologian, St. Thomas Aquinas, write that abortions were permissible if done prior to "quickening." That was generally the stand of the church in an era when the church was the state and the state was the church.

All was acceptable from the standpoint of the church and from a legislative standpoint according to medical and scientific limitations of the era until the decade of the 1860s. Then several events took place which raised new moral issues from the standpoint of the church and ought to have raised scientific questions about the legislative feasibility of passage of subsequent abortion statutes in the remaining states based upon the original legislative premise—"To save the lives of mothers!":

1. Sir Joseph Lister in England discovered the principle of sterilization and ushered in the era of aseptic or sterile surgery.
2. Metchnikoff of Austria devised his method of making the obstetrician's hands safe for delivering mothers free of infections and was dubbed "the savior of mothers" although he was adjudged to be insane.
3. Louis Pasteur in France discovered the techniques of immunization against diseases such as "lockjaw."

So, it was the work of these three scientists that removed the prime causes for the deaths of women incident to abortion procedures, operative infections and "lockjaw." Therefore, on a scientific basis, no another state should have passed an abortion law after the decade of the 1860s.

However, it was another scientific discovery in the 1860s, too, which forced a change in the moral outlook of the church referable to abortions. A German scientist by the name of Kober, engaged in experimentation in fertilization techniques in rabbits, rats, and minkdogs, saw a revelation in his microscope one day. He observed a sperm approach and penetrate the cell membrane of an ovum, drop off the tail and the head and neck, proceed to the nucleus of the ovum in the procedure which we know of as fertilization. When this information was disseminated to the Vatican at Rome, the

Pope in 1995 then issued a new dictum which states that all abortion procedures were criminal and destructive of life because it was now concluded that life began at conception because the soul was infused at the time of conception by the process now known as "direct" or "immediate animation."

Therefore, that which started out with a medical premise 75 years previous to 1995 had now developed a firm religious and moral stance, and it is this more recent religious and moral stance that now still constitutes the only statement to sensible legislative disposition of the abortion statute in 1975.

What are the religious and moral considerations here? These considerations accurately address themselves to that which is right, just and religiously correct as follows:

1. From a religious standpoint, interpretation of the Biblical story of creation gives us the right to ask the question about the infusion of the soul at conception. The story relates the fact that God created man in His own image and drew HE breath into man the breath of life and man became a living soul. The import here is quite clear.

2. The justice of legislating morality and religious precept in a democracy such as ours. One of the basic tenets of our form of government is freedom of religion and religious belief. Therefore, we must not legislate in any way that imposes individual religious precept on all of the people of this nation.

3. The fact that through the centuries no woman has ever been decommunicated from the church for having had an abortion incident to rape; nor have the products of conception aborted prior to the 5th month ever been baptized and given a Christian burial anywhere in the world except in one little province in South China. This appears to be the word without the deed.

4. The justice of a woman's right to her own personal being without being forced to become a ward of the state the moment that she becomes pregnant.

5. The scientific correctness of accepting half truths about the disposition of the soul during the biological aberrant of identical twinning, a situation in which the fertilized ovum splits in half with the identical halves going their own separate developmental ways, mirror images of each other. The question can be asked of the disposition of the soul (inviolate and indestructible) at the time of the split. Does the soul split also, and, if so, when does the half soul become a whole soul, or is one identical twin without a soul? These are questions that are also correct to ask.

6. The justice of forcing a woman, pregnant by virtue of rape, to nurture and give birth to an infant whose very presence within her represents an extension of the crime that the rapist forced upon her. It should be to such extent that if it is right and just to prosecute the rapist, it should also be right and just for the woman to prosecute the extension of the crime of the rapist growing within her body and a requested abortion without discussion should be in order.

7. The truth in the necessity for physicians to make a sincere decision when called upon as to who will live and who will die, given a situation in which a woman has a malignancy of the uterus and a viable pregnancy. If the physician carries out his pledge to treat the sick, then surgery or radiation is resorted to, the use of either one of which will result in the death of the developing fetus. While untended, the woman will surely die and perhaps the fetus also. This is not a new situation, and a decision must be made which certainly does not place the physician in the role of playing "God" in the taking or giving of life.

Now a word or two about the "happening" that has brought us to this point of deep controversy late in this 20th century. Ten (10) to fifteen (15) years ago the American Law Institute, with a 1/2 million dollar grant from the Rockefeller Foundation, set about to overhaul and update what was known then as the American penal code. This task went forward in the most intricate and thorough detail—statute by statute—including the statute on abortion. When the job was done, the American Law Institute gave this nation a new body of statutes called the Model Penal Code—contained in the Model Penal Code was the new abortion statute. This new statute was the pattern used by the early states of Colorado, North Carolina, etc., who were the first to change

their abortion statutes, bringing them into alignment with rational but accurate thinking in this era.

So, in essence, the lawyers started this ball "rolling" but ironically, there is too large a body of American lawyers who seem bent upon undoing the magnificent work done by the highest legal body in their profession.

Finally, in summary, let me make the following statements:

1. A sufficiently large fraction of religionists and the collective church are duty guilty of lack of realism and hypocrisy in that they have said and continue to say through their actions and with their lips that they neither approve of contraception nor abortion even when medically indicated. They would further have you to believe still that the only prevention for an unwanted pregnancy is "abstinence," knowing full well, however, that their own followers resort both to contraception and abortion procedures in actual practice.

2. Other moralists feel that the use of contraceptive devices constitutes the total answer but are totally unaware of the fact that none of the marketed and purchasable contraceptive devices are one-hundred per cent accurate; all of these devices have varying percentages of failure. Nor are the moralists in this group aware of the fact that the "loop" is simply a "glorified abortion" in that its use does not prevent fertilization but prevents implantation of the fertilized ovum into the wall of the uterus.

3. Yet other moralists do not rationalize that sexual discrimination allows a man to present himself for sterilization via vasectomy (a simple procedure done in a physician's office under local anesthesia) simply for the asking but force a woman requesting an analogous procedure (tubal ligation) to be subjected to consultations on a hospital level with request granted or denied according to the whim of the consulting physician and/or individual and differing hospital policy.

4. No one state needs to become an "abortion mill" with all of the so-called unethical advertising of its wares, as has been said of New York State, if every state in this nation would assume and live up to its individual legislative responsibility referable to this problem.

5. We must seek an end to the scientific and legal hypocrisy that keeps scientific products that could and would allow each woman to monitor for herself with the use of these products from the market—products allowing her to decide whether or not she would accept a pregnancy after each act of "intercourse." There are currently drugs available to be taken by injection or by mouth which would allow the woman herself to make such a decision if such drugs were not restricted because of local statutes.

The accusation that legalized abortions are a mechanism of race genocide against blacks is a deliberate distortion of truth and fact. The mortality rate for abortions is high in the black population because poor economy will not allow the blacks to have this procedure done under optimum conditions because they cannot afford to go to New York or to pay for hospitalization and a physician's fee to have it done under the fancy title of "a dilation and curettage for irregular bleeding." The situation of the availability of abortions and contraception by the federal programs for the poor are currently under Congressional fire, being used as a "political football" to such extent that, from month to month, no one can be sure if, in offering these services to the black and the poor, pay will be received for services rendered.

So where are we now legislatively? It appears that we have the following legislative choices before us as we look forward into 1975:

1) A repeal amendment to the Constitution (a long drawn-out legislative affair on a national and state legislative level) which will thereby afford a national imperative to all 50 of the states.

2) The continued revision of the various state abortion laws which will actually only serve to place the burden of specifications and indications for procuring an abortion, with all of its emotional and moral implications, on the respective states rather than leaving this moral and ethical decision to the patient and her physician.

3) Repeal of individual state abortion laws and placing the

whole situation back into the field of medicine where it came from.—This is my personal choice.

4) A national program of information to offset the current enactment of the Bartley Amendment to Senate Bill 66, which is before the Congress right now! A national mandate to set aside the verdict in the Edelin case, which is a national disgrace that was apparently used deliberately by the National Right to Life Organization as a landmark decision to kick off their national campaign to repeal the Supreme Court decision of 1973. The tragic import of the Edelin decision taken to the ultimate of interpretation means that any physician doing an abortion is within his or her legal right to do the abortion but can be held guilty of manslaughter if every measure to preserve the life of the developing fetus has not been exhausted from the day of conception to engage to developing fetus to the date of separation by birth.

5) Or for each state and this nation to just forget that the abortion problem exists through the mechanism of "ostrich behavior" (it is said that when the ostrich sees danger coming, it simply buries its head in the sand on the premise that if it cannot see the danger, then the danger does not actually exist). This decision will mean "business as usual with illegal and criminal abortions" and a return to the "Dark Ages."

The precedent for individual state action, in this respect, has already been set through the establishment of the unconstitutionality of such state laws by New York State, the District of Columbia, Hawaii, and Alaska.

In the final analysis, it is mandatory that a disposition of this impasse be made if for no other reason than the fact that, in a Democracy, we cannot and should not legislate morality (since this is what this issue has come to), nor must we seek legislatively to "saddle" all of the people of this Democracy with laws reasoned by personal religious belief and dogma.....

REFERENCES:

- 1) Historical Argument.....*Right to Control Reproductive Processes NOW*.....Barbara Sykes-Wright
- 2) *Therapeutic Abortion: Blessing or Murder*.....Robert D. Vowser
- 3) *The Law of New York.....A Case of Cessation of Constitutionality*.....Cyril C. Means, Jr.
- 4) *The Phoenix of Abortion Freedom*.....Cyril C. Means, Jr.
- 5) *Historical Background of Abortion Legislation in USA*.....Ti-Grace Atkinson

April 7, 1975

FEMINISM AND THE CULTURAL REVOLUTION IN HEALTH

by Barbara Ehrenreich

I want to talk about medicine as a system of social control. When I say it is a system of social control I mean it reinforces and promotes the ideology of the dominant class in our society. And that is an ideology which attempts to justify power inequalities based on race, sex, and class. I want to focus on medicine as a system for the social control of women, which means I want to look primarily at the role of medicine in promoting and reinforcing the ideology of sexism.

I realize this is an unusual way to look at the medical system. We are all aware of many institutions for social control in our society—the schools, the courts, the church, the psychiatric establishment, the welfare system—they are all more or less blatant about promoting the dominant ideology of our society. But, on the face of it, medicine seems to have nothing to do with ideology. After all, it's based on science, and science, we all know, is neutral. Doctors are merely technicians; medicine is merely the application of basic biological science to the human body—or so it seems.

Well, these precisely are the kinds of assumptions we have to re-examine—and not just as an intellectual exercise. Because if, as I will argue, medicine is a system of social control—if it is an important source of sexism ideology in our society—then that changes the nature of our struggle. We cannot just be asking for more care, or technically better care, but for a total redefinition of the nature of medical care and perhaps of medical science itself. In other words, we would need to have not just a revolution in health, but a cultural revolution as well. And from what I know of the projects and struggles of the Women's Health Movement today, I think that's probably what we're about anyway.

It's always easier to see the obvious when it's about a hundred years behind us, so let's go back for a few minutes to medicine in the 19th century.¹ The 19th century medical theory of women can be summarized very briefly: "Women were sick. More precisely, all aspects of the female life cycle were pathological—puberty, menopause, pregnancy, menstruation—and everything in between was pretty dangerous too.

Now this was not just some crackpot theory, or the idea of a few men on the fringes of their profession. This was the mainstream of medical science. It was written in the medical textbooks and taught in the medical schools; women are inherently frail, weak and sick.

I should qualify right away, doctors did not believe that all women were sick. Poor and working class women were extremely hardy. You could tell because they were able to work 10 to 14 hours a day in factories or sweat shops or as household servants. (Of course the truth was very different: poor women suffered much more than wealthy women from TB and other infectious diseases and from complications of childbirth—all aggravated by malnutrition and overwork.)

I don't mean to be cynical or anything, but there does seem to be something very self-serving about a medical theory which postulated innate biological differences on the basis of the ability to pay for medical care. According to the theory, the women who couldn't afford medical care didn't need it. And the ones who could afford it needed it all the time. But the myth of female frailty served the doctors in another way too: it helped to discredit women as healers. How could a woman—that is, a "lady"—perform a surgical operation if she were menstruating? How could she help but faint at the sight of nudity in either sex?

The basic physiological theory entertained by American medical men was a sort of "conservation of energy" theory: the organs of the body are in competition for a fixed supply of energy. Use one too much and you will drain all the others. Naturally, the theory had very different applications to the two sexes. For men, it meant that they had to avoid an excess of sex, which would drain the vital energies they needed for business, medicine, and other male pursuits. The opposite was true for women: too much intellectual activity would destroy a woman's reproductive powers. In his influential book, *Sex in Education*, Dr. Edward Clark of Harvard Medical School argued that higher education might literally cause women's uteruses to atrophy! This theory—which I would not advise anyone to rely on—was extremely widespread. President Theodore Roosevelt believed it and foresaw that women's admission to colleges would lead to the extinction of the white race!²

So I don't think there can be any question about it: 19th century medicine made very little attempt to conceal its sex and class biases with anything we would recognize as science. And if a woman didn't believe what medicine was telling her about herself—if she was uppity and wanted to get involved in the suffrage movement or something—there was usually a doctor around to prescribe a "cure": bed rest and abstinence from reading or conversation, gynecological surgery to "tame" her, or, most effective of all—heavy doses of opium.

19th century medicine did its bit for racism too. Perhaps the most outstanding contribution was the work of Dr. Samuel Cartwright in the 1850's. He discovered the reasons for the sullenness and uncooperativeness of so many black slaves. Namely, they had an inherent blood disorder. The cure, interestingly enough, was continual hard labor. If the disease

progressed the slaves might develop the worst symptom of all—running away, or as he called it, "drapenomania." This could be cured by the vigorous application of rawhide to the skin, i.e., whipping.

Now let us move on to medicine and social control in the 20th century. The first big thing to notice in the expansion of the medical system—in any dimension you would want to look at. The institutions have grown, the amount of money spent on medicine has grown, utilization has grown. But for our purposes the most interesting feature of this expansion is that there has been an expansion of the jurisdiction of medicine. More and more problems are considered to be medical problems; medicine impinges on people in more and more aspects of their lives. What we are seeing is the medicalization of daily life.

This is particularly striking in the case of women: pregnancy is subject to medical "management," as the expression goes. Childbirth is handled as if it were a major surgical event. Birth control for women, which was not available at all in 1900, is now available—but only through the medical system. Menopause, which 19th century doctors viewed pretty much as a hopeless illness, can now be "treated" with massive doses of estrogens. And medicine keeps expanding its jurisdiction all the time. If you are ugly, you can have your face lifted or your breasts remodeled (and if you're not sure whether you're ugly the doctors can tell you). If you're having sex problems, your gynecologist can help you, or at least refer you to a nearby sex clinic. If you can't relate to your kids, see your pediatrician or consult Dr. Spock or Dr. Glascoff. Modern medicine has a cure for everything!

Of course, few of us can imagine paying for cosmetic surgery or sex therapy. But I think the general point still holds. We live in a culture which encourages us to seek medical solutions to our problems, whether or not we can afford them. As women, we are encouraged to depend on the medical system from puberty, through child-bearing and raising, to menopause, until we eventually die a medicated death.

Has this expansion of medicine made us, on the whole, healthier? I don't know, and that is a subject which we need to continue to investigate. But the significance of this kind of expansion for social control is clear: the medical system is in a better position than ever to exert social control. As medicine has penetrated more and more aspects of our daily lives, it has come to be a more and more effective vehicle for sexism or any other ideology it cares to promote.

So today it is a matter of some urgency that we uncover and analyze medical sexism and other prejudices. You're probably thinking: What's the mystery? Everyone knows that most doctors are male chauvinists. Many of us have had the experience of being criticized by doctors for our lifestyles, or for the fact that we don't douche, or shave our legs or something. Or we've had our bodies criticized, like a woman who uses the same clinic that I do in Long Island. Her doctor told her that her breasts were "too small." Then he said, "Well, just so long as your husband's happy."

These are examples of doctors using their positions of authority, which are supposedly based on their scientific training, to put women down—to make them feel ashamed and inferior. Well, that's certainly medical sexism. But it's a random and individual form of sexism. The question is whether there are more consistent and systematic ways in which medicine operates to put women down and keep women down.

Let's look first at medical theories about women. An obstetric textbook widely used in the mid-19th century said, "Woman's brain is too small for intellect but just large enough for love."² Very quaint. Then we find in a 1971 obstetrics and gynecology textbook (one of the ones surveyed by Dianna Scully and Pauline Bart): "The traits that compose the core of the female personality are feminine narcissism, masochism and passivity."³

In general, medical theory still holds that women are innately "sick." Only in the 19th century women's ills were all traced to the uterus and ovaries. Now the source of pathology seems to be the female brain. There is a consistent tendency within "medical science" to view women's physical complaints as psychosomatic—all in our heads.

Example: from a 1962 gynecology book, reprinted in 1969: "...much of the physical and mental ill health of the individual woman can be properly understood only in the light of her conscious or unconscious acceptance of her feminine role."⁴ Example: a 1967 article in the journal entitled *Gynecetics and Gynecology* listed the following conditions as partially or wholly psychological in origin: menstrual discomfort, pelvic pain, infertility, habitual miscarriages, toxemia of pregnancy, and complications of labor. About all they left out was cervical cancer. Example: At Duke University Medical Center in 1974, a computer for diagnosis is programmed to give women 10 points toward a diagnosis of "psychosomatic" just for being women.

I don't think there is any question about this bias within medical science. Physicians like Estelle Ramey and the Lemnans⁵ have helped to expose it to us. It is definitely there; it is definitely part of what physicians are taught today as medical "science."

What is its impact on women? Let me give you one example. A woman I know—a woman in her mid-30's, with three children—a very level headed woman—developed persistent pain in her leg which eventually prevented her from walking. After numerous tests, the doctors failed to come up with a diagnosis which could account for her condition. A high-priced private surgeon whom she had consulted finally told her that all she needed to do was to try to take her mind off it. She called me in a depressed and tearful state: "I can't trust my own judgment any more," she said. "I had no idea that my problem might really be mental. Why don't they just send me to a psychiatrist and get it over with?" Her self-confidence had been deeply shattered; she became unable to make any decisions. (Fortunately her condition was diagnosed a few months later, and successfully treated.) This is an extreme case. But anyone who has had the experience of seeing a doctor about a physical complaint and being told it is all in your head ("all you need is to relax and take your Librium") knows the feeling.

The effect of the psychosomatic diagnosis, which is prejudicially applied to women, is to make the patient feel mentally incompetent, foolish and childlike. That is, the psychosomatic diagnosis reinforces conventional sex stereotypes and thus contributes to the social control of women in our society.

Now I'd like to look briefly at the doctor-patient relationship itself as a vehicle for social control. Things like the psychosomatic diagnosis are sexist "messages" which get transmitted in the course of medical care. The doctor-patient relationship is the medium through which those messages get transmitted. And the point I want to make is that the "medium" is a message too.

Everyone knows that the doctor-patient relationship is an authoritarian relationship. Partly this is because of the great respect for science which people place—or misplace—in physicians. Partly this is because physicians have tried to make it this way. For example, the medical code adopted by the A.M.A. at its formation in 1847 enjoined doctors to "unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence."⁷ (emphasis in original.)

Sociologists have described the modern doctor-patient relationship as an "authority/dependence" relationship; or even as a "domination/submission" relationship.⁸ Gynecologists have likened their own relationships to patients to the father/child relationship, the psychiatrist/patient relationship, and even to the God/mortal relationship.⁹

Now what does this mean? Every day millions of women seek medical care, often over very intimate problems. But the only way to get this medical care is enter into, however briefly, an authoritarian relationship with a person who is 93% likely to be male, 97% likely to be white, and at least 90% likely to be rich, or on his way to being rich. In short, the price of whatever technical help one receives is that one must undergo a rite of submission to a representative of the dominant group in our society.

The only analogy to this I can think of is certain feudal rites by which the vassals—the poor people—had to periodically reaffirm their servility to the feudal lord. Our medical system operates the same way: It brings people of low status and power in our

society—poor and working class people, non-white people, women—into relationships of domination and submission with members of the modern equivalent of the aristocracy.¹⁰

The only reason we don't usually think of this as a feudal rite of submission is that the whole relationship is mystified as a "neutral, technical" kind of transaction. But it is a power relationship and it does serve to reinforce the system of domination which characterizes the larger society: men over women, white over black, and upper class over lower class.

The overall point I am trying to make is that the medical system must be understood as a cultural institution. Doctors would like us to see it as simply a technological or scientific institution, distributing "cures" to the needy. Economists, and many health radicals, tend to see it as simply an economic institution—or a business. Well, it is a business, and a very profitable one at that. But I am asking you to see it also as a part of this society's vast cultural and ideological apparatus—an apparatus which is dedicated to the perpetuation and reproduction of existing power relationships. And in a sexist, racist and capitalist society—these are relationships of sex, class and race domination.

How could we change the culture of medicine? Well, we could all resolve to be apply, nonsexistive patients. But that won't get us very far, especially those of us who can't afford to patronize the few "liberal," non-sexist doctors—you know, the kind with sideburns and great big colored ties. We are only going to change the culture of medicine through our efforts as a movement. I can suggest two things we need to focus on:

First, we need to develop a popular, feminist critique of medical science and technology. For too long, so-called science has been a camouflage for sheer prejudice. There is nothing we can take for granted—even when it comes all dressed up with charts and graphs and high-sounding Latin words. A great deal of it, especially as applied to women, must be considered suspect until proven otherwise. I do not mean we should reject science—just because what passes for science has so often been used against us. I mean we should do what the physicians have never been able to do because of their own sex and class biases—we should try to bring science to medicine. We need a people's science of medicine which deals with real people's needs and experiences—not with some people's prejudices and stereotypes.

Second, we need to make a head-on attack on the hierarchy among health workers. I have talked a lot about doctors, but they are only about 10% of the health workforce. Over three-fourths of the health workforce is women. I didn't leave them out because I forgot about them. I left them out because they're not part of the problem. In the system as it's set up, they are virtually powerless. They're not consulted when medical theories about women are being concocted; they're not allowed to communicate with patients in any medically significant ways. Their skills are under-utilized; their talents are wasted; their contributions are ignored.

We would have a very different medical system if the majority of the health manpower—that is, the woman-power—had a leadership role in the organization and delivery of care. We wouldn't have sexist claptrap masquerading as scientific theory. We wouldn't be expected to pay for our care through our own humiliation.

What I am saying is that it is in the direct and immediate interest of women health care consumers to work for the abolition of the medical hierarchy which oppresses and exploits women health workers.

I want to say one last thing on the subject of social control, and this is something I only fully understood when I visited the People's Republic of China last year. In an ultimate sense, any health system, in any society, is going to operate as a system of social control. The fundamental human experiences of giving birth, of illness, of dying—are common to most or all people, and lead people in any society to seek other people out for help. Whatever mechanism a society has for dealing collectively with these fundamental experiences—that is, whatever form of health system it has—is necessarily going to reflect and reinforce the basic cultural values of that society, the kind of human relationships it tries to build, the value it places on individual human experience.

A capitalist health system reflects and reinforces capitalist culture. It builds authoritarian relationships between people. It devalues individual experience and degrades the individuals seeking help.

A socialist health system—and by that I mean much more than a "socialized" health system—reflects and reinforces a socialist culture. I got a glimpse of this in China: every effort is being made to develop a people's science of medicine—one which reflects the needs and traditions of the ordinary people. Every effort is being made to make health care be a helping relationship between equals. For example, the health workers one relies on for basic preventive care may be a fellow worker or a neighbor. Every effort is being made to break down hierarchical relationships between health workers and patients, and among health workers.

So of course there is an ideological message embedded in health care in China: it is a message of mutual respect and compassion and solidarity.

I think that is a very important part of what we are working for in the women's health movement today in this country. In a day-to-day sense it often seems like we are struggling simply in self-defense—for basic primary and preventive care for all women, for safe forms of contraception, for our right to abortion—or against the medical violence of forced sterilization or dangerous drug use. But the women's health movement today is not just fighting back. More and more we have been going on the offensive, building something positive, building a new vision and a new culture of health care. I think the self-help and self-help movements particularly are in the forefront of this offensive, pointing the way toward a new understanding of health itself...toward new relationships between people and technology...toward a new, collective way to understand and cope with the subjective experience of health and illness.

To me all this has an importance which goes even beyond health and health issues. The revolution we are working for is not just a change of administration. It is a total transformation of society in every realm—cultural as well as economic, "personal" as well as public. Building a feminist vision and culture of health care is part of the entire revolutionary struggle to turn this country around—to build a socialist and feminist society.

Let me end on a note about strategy. Because of the totality of the transformation we are working for, because we must overthrow not just the political and economic structure of the health system, but the capitalist and sexist culture of health care—because of all this, there is no one "correct" thing to be doing. The well-worn debate between the strategy of building "alternative institutions" versus "attacking the existing institutions" is getting us nowhere. Both approaches are essential. There is a danger only if they drift apart—if they should cease to reinforce and revitalize and inform each other. We can avoid this danger only by a strategy of pushing forward on all fronts, while at the same time working to deepen our common analysis and tighten the links between our many struggles.

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KEYNOTE ADDRESS

April 8, 1975

By Dolores Huerta

I am very honored to be here today, to have been invited to be a keynote speaker at the Conference. I guess what the Farm Workers are about and what you are about is pretty much the same thing and that is trying to make some changes, trying to bring about some good, and trying to do it through organization. That's a very difficult thing to accomplish, as all of the people who worked on this Conference know.

It seems that not only the Farm Workers but everyone in the country are suffering from the same thing. We have had an affliction placed upon us by people who are in power and that affliction happens to be misrepresentation. Everywhere that we look we find people cannot really get what they need and what they want. Somehow there isn't money and all that we know is money really isn't the problem. The problem is the people who control our lives. All of a sudden we all find that we really can't control our own destinies.

I'm going to talk just briefly about some of the attempts that have been made to organize farm workers. I think that what I have to say relates to the problem of organizing for health, as there are many similarities. We have found in our country that food is not grown to feed people. When you think of feeding people, that's a very sacred task. It's nourishment of the body; this is what food should be. But that isn't why food is grown. Food is grown to make exorbitant profits so they call it a deal. When you talk to a farmer, he'll tell you about the lettuce deal, the grape deal and the onion deal like it was a roulette game or a deck of cards.

You'll find the same thing with medicine. Medicine is not practiced to heal people, it's practiced for profit. And food is used politically to oppress people, to degrade people, to keep people in economic slavery. We find medicine is also used politically; the large masses of people cannot be healed, especially when, like farm workers, the conditions that they live and work under make it impossible for them even to eat enough food to have any kind of healthy body.

It is no accident that farm workers only live to be about 49 years of age. This is what they say is the average lifetime of a farm worker. I would venture to say that figure is not even correct. I would venture to say that the figure is even lower. We have seen among the farm workers that we represent, it is not unusual for a farm worker to have a heart attack at the age of 25 years. The reason is because the worker is worked to the point of bestiality. They have these horrible speed ups that make the workers work harder. I'm going to mention the Gallo Wine Co. which I think will give an example of the way farm workers are degraded and bestialized—worked like animals.

When we signed a contract with the Gallo Wine Co. in 1967, we had an election. Contrary to all other propaganda, we had an election there, we won the election and we negotiated a contract. I met with the Gallo workers to negotiate that contract. They were working 12, 14, and some even 16 hours a day. Now you probably say, how can anybody work 16 hours a day? The only way you can

do that is you take your bed roll and you lay it out there by the irrigation ditch and sleep on the job like these workers were doing. And these workers didn't have anyone to appeal to. They were from Portugal, from Mexico. They were literal slaves of the Gallo Wine Co. They were competing with the local prisoners for jobs.

Whenever the good brothers Amescio and Julio Gallo needed some extra labor, they just called up their friends at the local county Sheriff Office and said we need some people to pick our grapes and they would send over all the prisoners. They didn't have to pay the prisoners anything. I think they paid them something like 75 cents a day to pick the grapes. So if you wonder how Emilio and Julio Gallo's private family corporation got to be worth \$50 million, that's how—they got the grape pickers for free.

And they exploited people brutally to be able to get that big. A man who picks wine grapes picks tons of grapes in one day; not just one ton or two tons but several tons of grapes in one day. That takes a lot of running and a lot of stooping and at the Gallo Wine Co. the slowest worker of every crew was fired every day before we got that contract. Every single day the person who was the slowest got fired; that's how they always keep those people moving faster and faster. And they would hire more people (there were 5 and 10 farm workers for every single job) so they always had a very fast crew.

Now what did Gallo Wine do for their workers in terms of providing medical benefits for them? I don't know how many of you have seen pictures of the E & J Gallo camp #1 we've used on a lot of our leaflets. This is a horrible camp, a frame-house camp, this multi-million dollar wine co. had as a roof for those workers matted straw. That was the roof in their homes. The toilets and the showers had no floors in that labor camp. It was not a place worthy for people to live in. And this is the kind of housing they provided for their workers.

Now the Gallo Wine Co. is spending approximately \$13 million in a big publicity campaign to try to discredit the farm worker's union and Cesar Chavez to try to confuse the public. They also mislabel and mis-sell their wines. How much money has the Gallo Wine Co. spent on medical health for its workers? None.

Through our collective bargaining agreement with the Gallo Wine Co. we were able to extract 10 cents/hour from them to put into a medical fund. For three and more years, the Gallo Wine Co. fought our medical plan. They wanted us to take our money, those few dollars we had, and they wanted us to give them away to Blue Shield or Blue Cross or some other insurance company. We are so grateful that Cesar Chavez is a grammar school dropout and he wasn't confused with the idea that insurance is holy; he absolutely refused to take the farm workers money for their medical health and give it to an insurance company.

We had to fight with many people to do that, especially some of our doctor friends, and some of our liberal people. All of the "educated" people in the Union thought, how can you have a medical plan without going to an insurance company. Cesar said we're not going to do it. We had to fight Gallo, Christian Brothers, the wine companies we had contracts with and the other growers because they refused to have a medical plan without going to an insurance company. Even though we finally got it, we had to hold up our plan for two years. But we did get our medical plan, all by itself, administered by the Union.

We administered the plan. We have three employer trustees, and three working trustees. We were able to pay out to farm workers \$4.5 million in medical benefits, the money comes into the plan and it goes out to the workers. And the medical plan that we have for farm workers, which we also had to fight with the employers for, will cover a family of migrant workers. If the family works only 50 hours (that's one week of work), they're covered for a 9 month period. If the family works 250 hours they will get maternity coverage, surgery, hospital, x-ray, doctor's visits, prescription and so on. We have a fantastic medical plan for the workers, for 10 cents an hour.

The entire plan is administered by a woman farm worker, Maria Macaya, who came out on the first grape boycott. She has a fourth grade education in Mexicali, and she didn't speak a word of English when she came on the boycott in 1967. She does a

fantastic job. She has been audited many times and they've never been able to find a single mistake in the health plan.

In addition to having the health plan, we were able to do something else. Again, I think this is Cesar's genius: he starts from very basic things. If a farm worker wanted to go to a doctor in Delano, the doctor was also the local grape grower—every single doctor in Delano is also a grape grower. The kind of medicine this resulted in was horrible. We had one woman striker named Clara who went to a doctor because she wasn't feeling good. He told her she was pregnant. Six months later she found out she wasn't pregnant—she had a very severe case of tuberculosis. She lost one lung and part of another one. It's a miracle she didn't die. But she was one of the lucky ones.

Many farm workers who went to the grape grower doctors were always diagnosed badly. Of course if they didn't have money the doctors wouldn't even look at them. I personally have gone many times to the doctor with women who had babies sick with convulsions and the doctors refused to see them if they didn't have money in their hands.

During the first strike we decided we were going to change this and we started having our own volunteer doctors. We established our own clinics for farm workers. We built and rented space for our own clinics. This has been a medical revolution for farm workers; they can now go to a place where somebody really cares about them, she sees them as people, not as animals or a unit of production like the grape grower doctors see them.

I was in the hospital in 1973, because I delivered my tenth baby. The doctor told me our medicine was so good that we had changed the statistics of Paleri County. The medical statistics had been altered because our preventive medicine was so good. Our clinics are staffed by farm workers. We have farm workers in training, and we are desperately in need of doctors and nurses.

Delano, Palerito, Salinas, Fresno, these aren't very romantic sounding names, but there's people out there that have a great deal of needs. And anyone who would come to work with our clinics would find it a great rewarding experience. It would be a tremendous education in itself. We have one full problem, and that is that we don't pay wages. All of us, including Cesar, work for \$5/week for our food and \$5/week for our personal benefits. I think our doctors get a little bit better than that but some of them are so great they don't want to take any more than what the regular strikers get. This I know is a big sacrifice; we do make loan payments for people (medical loans or loans that they may have for education). But I would hope that some people would make that sacrifice to come and to help us with our clinics.

The reason that farm workers haven't been organized all these years isn't because they were lazy or stupid or that they didn't want organization. Every single time farm workers tried to organize, the organizations were crushed. Not only farm workers were crushed with strikes of violence and with deaths. If we look at the history of Black organizations or organization among Black people in this country, we'll see exactly the same thing has happened. Every single time that a leader has emerged, he has been killed and/or deported. There has been a lack of organization but not because people didn't try or have leadership. How many young Black leaders have been killed? Several hundred, right? We don't even know how many—200, 300, 400—it's in the hundreds. There is a sinister conspiracy to keep organizing from happening, whether it be among Mexican-Americans, Blacks, activists—this thing is all the time, it's there. These people, the reactionaries who don't want organizing to happen, are making sure that it doesn't happen. I think that the farm workers are a very good example of that. I've been telling you some of the great and wonderful things we were able to do for farm workers just in the area of clinics, in health—I didn't even talk about what happens out there in the fields where people go to work and "great, there's a toilet out there." The number one health necessity, a toilet, is out there because we have it in the contract. If you don't have a contract, there's no toilet. There's no cold drinking water, there's no first aid kit, no protection from poisons. These are the basic things, so why shouldn't they let us exist? Why should they not allow this Union to exist? That's a very serious question.

Why do the Teamsters, the UFWO, the CA Grape and Fruit Commission, the vegetable growers, the lettuce growers, Colson, Nixon, the Farm Bureau Fed.—all of those people who conspired to destroy our Union—who don't they want us to exist? There's only one reason: they will not allow organizations of minority peoples in this country. And that may sound unreal, but if you look at the history of what they have done, you will see that it is true. Because we are aware of this plan to keep people from organizing, we must organize ten times more, so they cannot destroy our attempts at organizations.

People with problems, be they health or political problems, farm workers, other poor, everybody, can solve their own problems if they get the proper representation. We can make that happen. I'm going to give you a few examples of what the farm workers did in Delano. In one little town called Richfield, CA they were trying to get the free lunch program, because even under Union contract they still didn't have enough food to eat. To get the free lunch program they voted out all the growers from the Board of Ed. They got together and had a big meeting like this one (only many more hundreds of people). They registered to vote and they kicked out the growers from the Board of Ed, and then they got themselves voted in. So guess what? They have free lunches.

They even went further than that. They got very militant; they brought in sewers, they brought in streetlights, they brought in ball service, and they brought in a day care center. The grape growers with all their millions of dollars, have never provided one service for the people who work for them. Part of the whole mentality of keeping people in oppression is to degrade those people, to make those people feel like they're not human. You don't give them a toilet, you don't give them drinking water, you give them the short handle to go to work with. And you don't provide them with decent housing facilities. The farm workers did something else. They moved out of the camps of the growers and built their own housing under the self-help program. If you could have seen Richfield, CA, in 1965 during the first strike and you were to go back now, you would not recognize that town. It's like two different communities, because the farm workers were able to solve their problems. So we know we can solve our problems. If people have intelligence they don't have to have a college degree to solve their problems. As Cesar Chavez has shown us, sometimes it's even better not to have it. People can solve their own problems if they are given a chance.

We now have a training program for organizers. The man who's developed this program is named Fred Ross. He is the man who found Cesar Chavez and taught Cesar how to organize. We are looking for organizers because we have found if we are going to be able to organize farmworkers, we have to organize the cities. We cannot lead our struggles out there in the fields. The growers will kill our people like they did in the summer of '73, when we had 14,000 farm workers on strike, 3500 in jail, and 200 beaten and hospitalized by the Teamster goons and the sheriffs. We had two who were killed. We can't win out there. We've got to bring our fight to the cities. So we are now organizing in the cities; we are going into communities and setting up organizations in the cities. And we need people to help us do that. We would like to invite any of you who have this passion for justice to come and join us and give us 6 months of your life. It's really like going to school for 6 months. When you work with the Farm Workers Union, you will learn all there is to know about economics, politics, psychology, psychology of leadership, and how to live without money.

(anecdote about Cesar left out)

Cesar joined Fred Ross in 1952. He worked with Mr. Ross from 1952-1962 organizing what they call the Community Service Organization. This is the Spanish-speaking group to make changes in the legislature, to get welfare legislation. They got the old-age pension for non-citizens, for the people who had given all their lives to the country and couldn't even get an old-age pension.

When Cesar started organizing farm workers, he went to their houses and got them together. The biggest problem he had, and I think it's the problem we all have, is he had to get the workers not to be afraid, to lose their fear of organizing. Now when you say it like that, it doesn't sound like a very big thing. But there are many

things that people are afraid of. They're afraid that they'll get into something; they're afraid to do things. But the gift that Cesar gave the farm workers and all of us—not to be afraid—was a very significant thing. I think that that's what we have to use as our number one criterion when we try to organize people: to have people get together and not to be afraid.

SPECIAL PRESENTATIONS

ON DEMONS, DRUGS, AND DOCTORS

by Mary Daly

[The following speech was written several months after the Conference, so it does not represent a verbatim account of Mary Daly's presentation. However, the ideas expressed both at the Conference and in this speech are quite similar.]

I am here to participate in an act of exorcism. To exorcise is to cast out demons. In order to cast out demons it is necessary to name them, to exorcise them. This is not easy, for women in a patriarchal world live in a State of Possession. In China, millions of women were mutilated by footbinding. Today our spirits are still mutilated by the mindbinding, spiritbinding powers of patriarchy and its myths.

The demonically powerful patriarchy who claim ownership of women's lives are representatives of the myth of male divinity. These Godfathers include the Godfathers of religion, of politics, of the media, of the professions. Included in their ranks are rapists, therapists (the rapists), industrialists who rape the land, the air, and the water, war-makers who even now plan thermonuclear holocaust, torturers who destroy the bodies and minds of political prisoners. Included in their ranks are the men of the Vatican and the CIA, those "intelligence" agencies who demand the death of the mind. Included in their ranks are members of that terrorizing trinity, the AMA, the FDA, and the drug industry.

In the State of Possession there are professional gamblers who gamble with women's lives, professional prostitutes who sell their integrity and blandly legitimate the mass murder of women, professional pushers who drug women with sickening medicines. The little Sir Echoes of this male monogendering system seduce women to doom and death, offered under the labels of happiness and health. A physician-authored booklet entitled *The Menopause: A New Life of Confidence and Contentment* asks: "Does estrogen cause cancer?" The doctor (Lindsay R. Curtis, M.D.) answers flippantly, "Only in mice." The response accompanies a cartoon of a middle-aged woman popping a pill from a bottle marked "Estrogen." The doctor elaborates upon his answer:

"No, in fact, there is now some evidence suggesting a LOWER incidence of cancer in women taking estrogen. Only in mice have estrogens been found to cause cancer, and then only when given in massive doses."

One might object that the pamphlet was published before the recent findings linking the use of estrogen to cancer were published in the *New England Journal of Medicine*. Those who are naive enough to think that such "findings" will automatically bring about change should listen to the views expressed by gynecologists around the country after these "findings" were publicized. Gynecologists indicated in a spot check, reported in *The New York Times*, (Dec. 5, 1975) that the new reports will have little effect upon their treatment of patients. *The New York Times* article in which the survey is reported gives as some useful material for the process of unmasking the demonic powers of the medical profession. I will note three points: 1) The doctors' attitudes were unchanged; 2) All the doctors emphasized that every patient treated with estrogen should be thoroughly examined every six months; 3) One of the doctors described the menopause as a "deficiency disease" and added that "most

Since the remainder of this speech did not record, and we have been unable to reach Dolores Huerta in order to "ad lib" an ending the last few minutes of the speech are not transcribed.

women develop some symptoms whether they are aware of them or not, so I prescribe estrogens for virtually all menopausal women for an indefinite period" (statement attributed to Dr. Rubin Clay of San Francisco).

What is unmasked here, both in the pamphlet and in the response to *The New York Times* survey, is a phenomenon called "atrognesis." The word is derived from the Greek terms for "physician" (*tauros*) and for "origins" (*genesis*). *Atrognesis* means doctor-made disease. It describes a fact about modern medicine, namely, that it is sickening, that to a great extent it does the opposite of what it claims that it intends to do, that is, to cure. The fact of the morbidity of modern medicine has been well documented, for example, in the scathing analysis written by Ivan Illich in a recently published book, *Medical Nemesis* (N.Y.: Pantheon, 1976).

Let's look at some symptoms of the morbidity of medicine revealed in the pamphlet and survey I quoted a moment ago while recognizing that these are typical of thousands of such items available for popular consumption, and which contribute to the mind pollution which pervades the environment in the State of Possession. First, there is a debilitating and trivialization of "patients," specifically women labeled as patients. Second, there is a refusal to acknowledge the evidence of medical morbidity, in this case, specifically, refusal to acknowledge the reality of estrogen-related deaths. As usual, we are told that there isn't enough evidence, that the link-up between drugs and death has not been "proved." Clearly, no matter how many women die, it still will not be proved to those who do not want to know. This second phenomenon, the nonacknowledgment of evidence, is linked to the first, namely, the trivialization and objectivization of women labeled as patients. Once a person is reduced to an object with the status of "patient" rather than of "agent," she is the target of callousness masquerading as scientific detachment. She is the object of sick humor, sickening treatment (surgery and drugs) and sickeningly deceptive statistics. A third symptom of the morbidity of medicine is indicated in the doctors' insistence that their "patients" treated with estrogen be thoroughly examined every six months. What this implies is more and more control over women, increased dependency and loss of autonomy. We live in a society which is becoming one vast hospital. More and more women are being told that they—and their children—have been damaged by previous medication and that new treatment is required which is conditioned by the consequences of the previous treatment. Another point about these frequent and "thorough" examinations should be noted, namely that they are fixated upon breasts and genital areas. We have reason to wonder about connections between the breast fetishism of this culture and the horrifying rise in incidences of breast cancer, and we have reason to see link-ups between the genital fixation of the rapist society in which we live and die (a fixation now glorified under the rubrics of the so-called sexual revolution) and the genital fixation of morbid medicine. It is utterly characteristic of such a society that most of its gynecologists are men and that most people do not see anything strange or unusual about this fact.

A fourth symptom of the morbidity and misogyny of masculinist medicine is evident in the doctor's description of the menopause as a "deficiency disease." In the technological tomb which is modern phallic society, a natural process of women's bodies

is viewed as a disease to be "treated." A fifth symptom of the sickness of medicine is the bizarre claim (not peculiar to the one gynecologist cited) that "most women develop symptoms whether they are aware of them or not." This is an indication of medical expropriation of women's power to judge for ourselves, to know about ourselves, to prevent illness in ourselves, to heal ourselves. In the state of Possession, women are injected with false needs and false consciousness.

We will not be effective unless we see murderous medicine itself in its total environment. This is an environment controlled by masculine/male gender vested interests. The basic vested interest of masculinist/rapist society is destruction and death, not health and life. The professions of the professionals are circular, going nowhere. Religion feeds upon "sin" and creates it in order to prosper. Law feeds upon "crime" and creates it in order to prosper. The economy feeds upon war and creates it in order to prosper. The medical and paramedical professions and the drug industry feed upon disease and create it in order to prosper. This is the true "story of O," of the death march of patriarchy. Within patriarchy, women are the primordial enemies, the targets for rape, the paradigm for all of the other "enemies." The omnipresent "enemies" of patriarchal paranoia are sometimes named as demons, sometimes as political adversaries, sometimes as criminals, sometimes as witches, sometimes as sinners, sometimes as insane, sometimes as sick. At the present time it is convenient to label women as "sick." This places us under the control of labels, transforming us from a threat to a support for the system.

Enactment requires a rejection of this false labeling, of this false naming. It is essential that women have the existential courage and pride to name the demons in this necrophobic network of professions and vested interests. Since the controllers of the deadly society are paranoid, it is predictable that they will attempt to name women who resist feminists as "paranoid." I suggest that we gladly accept this label, transforming its meaning. There is a popular poster which says: "Just because you're paranoid doesn't mean they're not out to get you." For the victims of a societal structure that is "out to get us," recognition of this fact is healthy realism. It is positive paranoia. In fact, the word paranoia is from two Greek words, *para*, meaning "outside of," or "beyond," and *nous*, meaning "mind." Our survival requires that we move outside of and beyond the racist, murderous mind-set that attempts to mastermind and undermine our lives and our deaths. Basically, positive paranoia means seeing the patterns and relations that are really there between seemingly disparate parts of reality. It means seeing according to the ecological principle that "everything is connected with everything else." This is a Gyn-Ecological principle, the vision that comes when women have the courage to see and to name the forces that would oppress and possess us and—more important than that—to see and to name our own selves.

This naming of our own selves, this refusal of false labeling, is enactment, the casting out of demonic powers that invade our minds and bodies, keeping us footbound, mindbound, spellbound. Since enactment is moving outside of the masterminded mind-set that has possessed us, it is a psychic journey. It is a journey of ecstasy. Literally, "ecstasy" means "standing outside of." For women who are prideful, deliberately defiant and defiant, ecstasy is possible. This means that we will move spiritually and physically outside the space, the role to which we have been confined.

The problem is not one merely of escape from the religious, technological, and medical Mafia. So long as we are only escaping we are still in some sense passive, re-active. We have to find within ourselves the vision and courage to reclaim our own deep process of becoming. This process is beyond mere escape. It is a process of spiriting ourselves. By "spiriting" ourselves I mean freeing the life force which has been frozen, thoughtified, reduced to a caricature, fetishized, shrunk to a false statistic. By spiriting I mean reclaiming our own power to heal ourselves, refusing insofar as possible to be captured by the rituals not only of the grisly witch-doctors in black who condemn women to hell in the name of "holiness" but also of the witch doctors in white,

who condemn women to death in the name of "health." By "spiriting" I mean refusing the patient role and becoming the agents of our own healing. Spiriting means regaining the knowledge and power of our forecursors who were the forerunners of the modern medicine men, who were burned by the church as witches because they knew too much. As the proud daughters of these witches we must lay hold of the knowledge and power which is rightfully ours, which has been stolen from women and hidden from us by the witch-doctors, those shrunken mimics of our forecursors the witches, those male stalemated medicine men who are impotent to heal because they are part of a carcinogenic system which lives on death. By spiriting I also mean the sharing of knowledge among women, that we may create an environment within and among ourselves that is biophilic, life-fostering. This creation of a life-fostering environment is first of all the creation and dis-coverry of a life-loving state of mind. It is here, in our own deep spiritual resources, that we will find the only genuine "preventive medicine."

The call to spiritize ourselves is a call to transfer our energy to a nurturance and support of ourselves and of other women. Within patriarchy, women have been energy sources for men. As victims of this vast vampiric system we have been sapped, drained, used, possessed. Behind the problem of the Pill, of DES, of estrogen replacement therapy there is a deeper problem, the problem of possession. Our basic task today is not to mourn, but to learn to be free, to name for ourselves what it means to be free. This means exorcising the myths of phallogocentric society, which we have imbued from fairy tales, from pornography, from theology, from an "educational" system which stupefies, from media which seduce us subliminally, from doctors and legitimized junkies who fill us with falsehoods.

This call is in a real sense the "call of the wild." That which is wild is (as the dictionary admits) "living in a state of nature," "being one of a kind not ordinarily subjugated or domesticated." It also means "not inhabited or cultivated, uncontrolled, inordinate, ungoverned." Moreover (again according to the dictionary) it means "unruly, ungovernable, restless, (of a ship) hard to steer." It means "extravagant, fantastic, visionary." It means "rude, uncivilized, barbaric." It means "not accounted for by any known theories." Wild means "growing or produced without the aid and care of man; brought forth by unassisted nature."

The call of the wild is call from the Goddess, Nemesis. Nemesis is the name of the Goddess of divine retribution. Nemesis is righteous anger. Nemesis (not fully understood by Ilich, who uses her name in the title of his book, *Medical Nemesis*) is the wild witch who lives in every proud and courageous woman who dares to exorcise the racist would-be gods of the Land of the Fathers. The names and condemns the sins of these fathers. Most important of all, she names herself. She knows that the cost of failure will be exactly Nothing. In the face of this nothingness, this patriarchal "story of O" she proclaims the Female Principle, she creates the healing female environment, our "O-Zone," reclaiming our symbol from the possession of those who have tried to reduce our symbol and our womanselves to zero. She says: I am Spirit; I am Wild; I Am.

WOMEN PROFESSIONALS IN THE FEMINIST HEALTH MOVEMENT

Presentation by Carol Downer

When we started our Self-Help Clinic we did so because we were determined to gain control of our own bodies and we were angry about the treatment we had received from the male-dominated medical profession. We demanded the control of our own bodies. We demanded increased use of paramedics, more preventive health care, less dangerous drugs and surgery, and more humanized treatment. We demanded these changes in our right.

Then, as we talked to more women, we became even angrier and it became inescapably clear to us that it was a necessity that we use our collective efforts to take back control of women's medicine. It wasn't enough to become more sophisticated consumers, or to form lobbies to press for improved health care delivery, or to become more able to take care of our everyday health needs, including regulation of our own menstrual periods. All of these are vital steps, but our eventual goal must be to control the institution itself.

During this early part of our development, we also learned more about women in medicine. Of course, we knew that most women were encouraged to become nurses instead of doctors and that nurses often were relegated to the role of maidservants of male doctors, and that the few women who persevered to become doctors did not choose to specialize in women's medicine. We knew that few women were in medical research or in high administrative posts at medical institutions. But our contact with nurses revealed that same, sound approach to the healing art has not been completely eradicated. Nurses are trained to keep people well, to create an environment in which people can get well, and to help each individual utilize their strengths to withstand and overcome illness.

We saw that nurses, who are usually from a powerless group, women, have not been permitted to implement their training. Crisis-oriented, technology-loving male doctors head up the medical institutions and they've used all our resources to build up empires of concrete and brick hospitals containing expensive gadgetry, while the other activities of health care go neglected. But, even though that training is now going to waste, it exists. If we can challenge the thinking, such as described by Herbert S. Dorenberg in his article "The Wasteland" in *Progressive* magazine of April 1974, that results in having eighteen open-heart units in Philadelphia when only four do enough procedures to be economically feasible or medically sound, then we can bring about these changes immediately. Especially when you consider that 80% of health workers are women and the majority of patients are us, demanding the 20% to its rightful status considering its proportion is only reasonable.

The Self-Help Movement and the women in medicine must join forces to challenge and displace the present medical authorities and bring in a new age of enlightened humane health care. In this struggle we can expect support from many groups in our society that are trying to reform health care delivery.

But why, you may ask, do we have this incidence upon women taking care of women? Granted that some doctors have unfortunate attitudes toward women, you may insist that we can somehow change those attitudes and that all will be well. It goes much further than that. Sexist attitudes are a cause of inferior health care for women, of course. For example, male doctors frequently humiliate us in the examination room with sexist behavior; they have forced us to give birth in dehumanizing, dangerous ways for their convenience and profit; they have withheld abortion care to uphold nationalistic pro-natalist policies, and then they have administered harmful birth control methods when those policies change to anti-natalist; they have performed unnecessary and mutilating surgeries upon us. All of these effects of sexist treatment are presently being documented by noted women researchers and writers. We have reams of articles and books that describe our experiences so graphically and in such detail that, even though it is written in a carefully understated, matter-of-fact manner, it is shocking. For example, we read with horror of a generation of women facing a completely new, doctor-created disease, vaginal cancer, which affects those whose mothers took Diethylstilbestrol during their pregnancy. The current treatment is removal of the entire vagina. Kay Weiss, in a letter to the editor of *Ms.* in the May 1974 issue, wrote: "Pharmaceutical records recently examined reveal that approximately three million daughters were born of the DES pregnancies. It is now thought that 90% of the DES daughters have undetected adenosis which may be pre-cancerous" (page 13). Doris Haire, in her pamphlet "The Cultural Warring of Childbirth," presents the result of the worldwide study of

childbirth practices that show that American methods of obstetrics are the reason for our disgraceful infant mortality rate and that they cause brain damage to countless infants who survive the process. Our visit to France and Holland last fall revealed that these methods are now spreading in Europe and midwives are being driven out. Now, as doctors are beginning to regard sexuality as being in their territory, this sexism will have even wider scope and hurt us even more deeply.

So, sexism is all too real, but there is a deeper support for prevailing medical practices, professionalism, and unfortunately, women in medicine who deplore the brutal practices perpetuate them by clinging to professionalistic attitudes.

As we discuss professionalism we do not mean professionalism in its best sense—that is, having pride in one's work, consciousness towards one's responsibilities and genuine caring for those under one's care. That kind of professionalism is abundant in most of the women in medicine that we have known and distressingly lacking in many men in medicine that we have known.

The kind of professionalism that we think is destructive and keeping women in medicine from taking a stronger, more successful stand against incorrect practices consists in taking an area of human activity, such as the upkeep of our physical selves and hoarding up all the lore and knowledge that we've built up over the centuries in our various cultures, packaging it, sharing it with only certain select people in our society, then dispensing it like a product to those who are able to pay for it. We're talking about the kind of professionalism that consists of mystifying simple body functions, such as menstruation, orgasm or common vaginal infections, creating an artificial helplessness in us so that we must seek expert help to see if our menstrual cycle is "normal" or to achieve orgasm, or to tend to an everyday condition. Then, after having deprived us of basic knowledge about our own bodies, we are held up to ridicule for being ignorant, and this ignorance is used as a justification for increased mystification.

We object to the kind of professionalism that regards health care as a product instead of a process, putting human beings on an assembly line and separating out the parts of the process so that only the most profitable parts are reserved for doctors. For example, the lucky pregnant woman in our society receives pre-natal care, most of which consists of history taking, pelvic examinations, urine tests, weighing, etc. The usual ten or eleven office visits often involve two hours of waiting, inside and outside the examining room, a few hours of a nurse's or a medical assistant's time and five minutes of the doctor's time. Then she will attend childbirth education sessions and learn exercises and proper birthing behavior. These ten or twelve sessions will cost her perhaps \$5 an hour. Then, when she is admitted to the hospital, all the staff, supplies and equipment, drugs and the use of the room will cost about \$350. The doctor who will wait until the delivery room gives him a call to say that birth is imminent to come on the scene for an hour or so, will get paid \$450 for his efforts.

Pretty neat trick, isn't it? By parceling out the responsibility to lower paid workers, the doctor maximizes his pay. Incidentally, a hospital administrator remarked to us the other day that 80% of the babies in the hospital were delivered by the nurse. In our abortion clinic, we observe that our doctors make between \$80 and \$350 an hour, depending on their fees and whether or not they bill for Medi-Cal. The lab technician, the doctor's assistant, the counsellor—all are paid between \$3 to \$5 an hour. Some difference. So professionalism is profitable—for the physician.

Of course, creating a monopoly to up the price of a commodity is hardly new. It is a time-honored economic tactic. Very effective for profit-making, but hardly desirable when trying to improve health care.

Professionalism is a warped kind of unionism. Everybody sticks together against the enemy. It's the "we" against "them." Only in this case the "them" are sick people, women and children. This loyalty to the profession rather than the patient makes for an awesome challenge to the patient who finds herself isolated and helpless in an atmosphere where the staff bustles about cheerily

and comfortably, blissfully unaware of her anxiety. When someone says their hospital or clinic has a cheerful, relaxed atmosphere, we ask, "Who is cheerful and relaxed?"

So, to discover ways that the Self-Help Movement and women in medicine can work together, we must re-examine professionalism and eliminate those aspects that are anti-health, anti-women, and anti-human. We must also look into our own reasons for maintaining these structures. We understand that many women have taken medical training and have been credentialled by these structures, and must support them because it is the only way they can prevent themselves from being pushed down into an amorphous mass of semi-skilled women who perform many medical tasks in doctors' offices and in hospitals for sub-standard wages. However, this reaction to the male medical profession's desire to keep women in low-paid subservience takes the form of trying to exclude lay women from the health care field.

It is also a sad fact that many women in medicine share male physicians' contempt for women. They have believed the male myths of female stupidity and think that midwives were dirty old women who spread "old wives tales" and that medicine was in a deadfall primitive state until an assortment of male saviors in the last century discovered disease organisms, developed aseptic techniques and miracle drugs. In fact, improved sanitation and better living conditions are probably larger factors in the achievement of a higher state of health. Many women in medicine do not want to be associated with "granny midwives." To them it is a put-down. At a meeting of nurse-midwives, I was distressed to hear one nurse complaining that doctors are now teaching housewives all about family planning.

These anti-woman attitudes help to perpetuate male dominance. They also alienate medical women from their sisters, depriving them of a power base for their struggles. We feel that the Self-Help Movement offers a much broader base of support of giving medical women more power.

The task is immense. The fortress of male-controlled medicine is established on a world-wide basis. It controls hundreds of thousands of health workers by means of a system of certification written into the laws, and is supported by tax and insurance dollars. This fortress has been built in the last hundred years though, as Barbara Ehrenreich, medical historian, commented in her speech "The History of Women Healers" at University of California at Los Angeles in April 1974, "In the nineteenth century in this country, various sects piled their arms. Most of the sects had many women involved in them, but the one that ultimately prevailed was an exclusively male group—the allopaths. This sect had a system of medicine which believed in disease that must be cured by remedies that produce effects different from or opposite to those produced by the disease. Most of the treatments have been abandoned, but the idea of making an assault on the body or organism has persevered. Ever since they gained an ascendancy over the other sects, they have worked relentlessly to stamp out or subordinate all other approaches to medical care." Today, our impression of medicine must be similar to that of the medieval European's view of religion. Today, "medicine" means drugs and surgery administered to sick people; then, "religion" meant the Catholic Church. To challenge either definition is heresy, heresy that has exactly the same results—harassment, economic isolation, ridicule and death.

The Self-Help Movement also challenge this definition. We want to see many areas of our life restored to our own personal domain; we want control of our own bodies. To do so, we have to consider why the allopaths won out. Why not the homeopaths or the herbalists? We think that it was that the allopaths' system of medicine that was useful for maintaining an industrial society; therefore it was supported by those who needed a large, well-disciplined work force. Under this system, productivity and ability to meet the needs of industry have become the criteria of health. Drugs and surgery have been used to make each of us fit into the industrial scheme. If we can't perform our housewife's chores, give us tranquilizers to keep us going. If we have a cold that might cause us to lose work, give us an antibiotic. To get medical insurance we must be workers.

Also, allopaths were men, who like the males from whom they drew their support favored popular technological solutions, and formed medical institutions in the image of the factory. At this time in our history, industrialists were ripping through mountains to lay railroads, laying whole forests to waste and glorying in the concept of mankind reigning supreme over natural forces. Man "harressed" or "tamed" nature. Meanwhile, women who practiced the gentle art of healing using tender loving care and natural remedies were characterized as "grannies" and their teachings as "old wives' tales." So, if we are to accomplish the Hygeian task of taking back women's medicine so that we can repudiate this mechanistic, chemical model, we must know our own common heritage.

Not much information is available to us about women in medicine in non-western cultures. Some may be asking, "Do you want to abandon all the medical advances of the last century and go back to primitive medicine?" Used with great caution and when appropriate, the drugs and surgical techniques and technological equipments can be a boon. We hardly regard indiscriminate use of radical mastectomy or tranquilizers as advances, however. Dr. Kate C. Mead in her address to the graduating class of the Female Medical College of Pennsylvania in 1929, identifies seven important periods in the evolution of women in medicine in the western culture. She begins with the Golden Age in Greece and the work of Aspasia and Agnodice, then she describes Greco-Roman times when women doctors practiced widely and freely, according to Pliny. She cites Galen who mentions that in the early Christian period women "systematically organized for effective medical service, not only conducting religious meetings, baptizing converts, but also healing the sick, feeding the hungry and trying to obey Christ's social teachings to the letter." Persecutions of the Christians stopped most of these activities and then the Christian Church relegated women to inferior roles. Mead reports that in the eleventh century, after six hundred years of darkness, Italian women rose to medical prominence, Trotula in particular. A hundred years later, Abbesses in Germany ruled Catholic institutions and practiced and taught medicine; Heloise and Saint Hildegard were outstanding figures. In the next period of darkness, millions of women were burned as witches, even though women had full control of midwifery and provided the only available medical care for everyone but the wealthy, then clerical the male doctors naturally reserved for themselves. Then during the sixteenth, seventeenth, and eighteenth centuries, there were famous midwives in France, in Germany, and in Holland.

The seventh and most recent period that Dr. Mead identifies begins with the determined efforts of Elizabeth Blackwell and others to force their way into nineteenth century male-dominated institutions. Their frustration resulted in the establishment of several medical schools for women, and by 1877 in the United States there were five hospitals managed by and for women. Most of us know that their courageous struggle for women's medicine was betrayed a few years later by women who gladly abandoned the all-women institutions when they began to get a foothold in the male medical schools. It was a tremendous mistake. By the turn of the century, these women's institutions were taken over by men and fewer and fewer women got into medical schools to become doctors until the very recent upsurge of Women's Liberation which has forced the doors somewhat open again.

We in Women's Liberation have learned that our struggle is tied in with all human beings' struggle for equality and for a safe, healthy, dignified existence. Similarly, women in medicine must learn that their struggle is tied in with ours. They must identify themselves first as women and support us and look for support from us. Otherwise, isolated from their sisters, they will form a powerless minority in their profession, and will be forced to survive through servility and total conformity.

In our struggles, we have evolved the following principles. If women in medicine can agree to these principles, then we have a basis upon which we can begin to work together to regain our heritage.

1. All women have a right to control their own body.

2. A woman will exercise responsible reproductive control if allowed to.

3. All women can, through regular self-examination and sharing with other women, take better care of their own bodies.

4. Menstruation, orgasm, childbirth and early abortion are ordinary, healthy events and should be treated as such, and we have the right of direct control of them, both as individuals and in groups.

5. Any specialized skills in assisting us with these functions should be practiced by women only, and any licensing agency should be limited to surveillance and investigation of complaints, and to ensuring that practitioners accurately represent their training to the public.

6. Women's hospitals and clinics should have the same funding as all other medical institutions.

7. Women who are on the staffs of women's clinics and hospitals should have the same access to training, to belonging to staffs of other hospitals and to all medical associations and societies.

8. Women's medical schools are needed.

9. Preventive medicine and high quality health care should be our priority. The indiscriminate use of surgery and drugs to deal with health problems that merely enable the individual to continue functioning in an unhealthy but adaptable manner with her status quo is using medicine as a status of social control rather than as a service to the women.

Previous efforts to bring women into medicine in the recent past have focused on allowing women to attend male-controlled medical schools, get licenses from male-controlled licensing agencies and then to practice in male-controlled hospitals in a severely authoritarian, hierarchical, professionalistic atmosphere. While we recognize that high quality medical care depends on health workers having training and discipline, giving conscious attention to medical routine, and that some individuals will have special responsibilities and special training and expertise, we also insist that the hospital has to be made into a more humane setting for women, especially well women who do not need the same type of care that sick people need, that they should not be isolated from the community and that the staff relationships should be more on the team model than the military model. Skills should be shared as much as possible; demystification is necessary, and egalitarian principles should guide us at all times.

We must recognize that the problem is global in scope and that women of all classes and nationalities must join in. We must also recognize that the problem may have its roots in elemental male prejudice, but that the present unjust situation is being maintained by not only certain professional interests, but also by those who wish to control women's reproduction.

That's all.

Helen Marinsek, in commenting on the seven periods of women in medicine in her address "Women's Health Movement, Where It Is and Where It's Going" which was delivered at the University of California at Los Angeles in April 1974 calls attention to the fact that the decline and fall of each of the historic periods of women's prominence in western medicine was caused by excluding women from the formal learning centers, by relegating their medical skills to narrowly defined fields and by blatant misogyny, justified whenever possible on medical or religious grounds as to women's weaker physical condition, hysterical nature, innate stupidity or basically evil intent.

The lessons of history are clear. The Self-Help Movement has analyzed the reasons that we women cannot get good health care, and we have pointed the way to the solution. Although achieving this solution will no doubt require all our commitment for all of our lives, we are on our way. Women in medicine can continue to suffer frustration and abuse by questioning collaboration with the present oppressive structure, or they can join in with us and work for the victory that will eventually be ours.

April 1975

PRESS STATEMENT OF THE DES CAUCUS OF THE 1975 CONFERENCE ON WOMEN AND HEALTH

Presently we are witnessing two unique occurrences in the field of public health: the first demonstration of transplacental carcinogenesis in humans, and the first drug-induced cancer epidemic in women under age 32. During the period 1943-1970, supposedly healthy mothers-to-be were given a drug commonly known as DES to preserve pregnancy. Widespread use of this drug, largely based on two uncontrolled, ill-defined studies, produced a population of women exposed to the drug in fetal life which resulted in an increased incidence of vaginal and cervical cancer. An equally irresponsible use pattern is being repeated today in the form of a morning-after pill—again, on the basis of uncontrolled and ill-defined studies. Neither the effectiveness of this drug nor its safety for this purpose was sufficiently demonstrated before its approval for this use. We find this appalling and inexcusable. DES as a morning-after pill is being given to the very population at risk, women of reproductive age and, in particular, DES daughters. In addition, there is the possibility of a new DES-exposed offspring resulting from the administration of the drug as a morning-after pill.

In light of these facts, we make the following demands, that:

(1) Congress must, at minimum, enact the pending legislation proposed by Senator Kennedy to take the drug off the market as a morning-after pill for one year, and to ban DES from use in livestock.

(2) FDA and pharmaceutical companies must bear the financial costs and educational responsibility for this doctor-produced disease and its consequences.

(3) Estrogens must not be taken by any women exposed to DES, including women who took the drug during pregnancy.

DES—Banned for Cattle, Prescribed for Women? A Background

Between 1945-1970, DES, a synthetic estrogen, was prescribed to millions of pregnant women as an ineffective "anti-miscarriage" drug. It is associated with the development of vaginal and cervical adenocarcinoma in 220 of the daughters of these pregnancies. There are 3,000,000 DES daughters in the U.S., many of whom have not yet reached puberty, when the cancer develops. Epidemiologic studies indicate that 90% of these 3,000,000 daughters are expected to develop vaginal adenosis, which may become a precancerous condition. Although vaginal cancer in daughters exposed to DES *in utero* provided the clinical evidence to secure an FDA ban on DES as an additive to cattle feed, the FDA recently approved a new use of DES as a contraceptive for women, even though it contains 825,000 times the amount of DES banned in beef as "unsafe for human consumption." Recent Congressional hearings revealed that U.S. physicians have been administering this "morning-after pill" to millions of women without informed consent. Women have not been advised before being administered the "morning-after pill" that a family history of cancer is a contraindication for this drug. The National Institute of Health has awarded contracts to universities and family planning agencies to administer the morning-after pill, even though the target population is composed of the "DES daughter" generation, whose adenosis could be exacerbated by DES. To date no public health agency has informed the generation of DES-daughters of their exposure to the drug or of their need for testing and treatment.

With This History, FDA Approval

February 5, 1975, FDA approved DES for use as the "morning-after pill." DES has been on the market since 1942; it has never been taken off the market for use on women.

Approval was recommended by an OB/GYN commission on the basis of ill-defined, uncontrolled study, most of whose subject patients were not followed up.

The basis of FDA approval was that "DES is UNPROVEN TO BE NONSAFE."

Packaging instructions state that the most serious side effect is the morning-after pill is abnormal clotting which could be fatal.

Surveys by Kay Weira have brought back reports of many more side effects, such as diabetic attack, hospitalization and sickness. They also revealed that women in studies were not followed up to determine the effectiveness of the drug.

Ninety per cent of DES daughters now have vaginal adenosis, possibly pre-cancerous lesions. (Adenosis: abnormal glandular tissues.)

The morning-after pill was used widely without FDA approval from 1970 to 1975.

Any kind of approval by the FDA is likely to increase use of DES, which seems to have few positive effects, is an extremely dangerous drug, and is contraindicated for many women who nonetheless have been prescribed DES.

Third World Women's Caucus

The Third World Women's Caucus made the following demands which were released at the press conference Saturday:

- 1) that provisions be made for adequate health services and facilities in Asian, Black, Boricua, Chicano, and Native American communities.
- 2) that the community maintain control of these services and facilities
- 3) that there be an immediate end to all forced sterilization and experimentation on third world people

We have asked the women at the conference to support these demands.

In addition, we want to say that we are well aware that the conference was essentially a segregated one which recognized third world and working class women as tokens and did not speak to their needs.

Conference participation by third world and working class women was negligible except in those workshops and events coordinated by the Health Coalition for Third World Women. Conference attendance also reflected a serious lack of communication to these communities.

We demand a commitment from the Women's Health Movement to insure fair representation to third world and working class women in the struggle. Until this happens, the Women's Health Movement is not a legitimate movement addressing itself to the needs of better health care for all women and their communities.

TIPS TO OTHER PEOPLE

By Jean B. Miller

"A further discussion of this and of related topics is contained in Miller, J.B. Towards a New Psychology of Women to be published in September, 1976, by Beacon Press, Boston.

Even in a position of subordination, women have developed many valuable psychological strengths. These are precisely the strengths that the dominant male society, and the theories which arise from it, would not perceive as strengths. Within a condition of subservience, there is a constant tendency for these strengths to be seen as weaknesses.

I'd like to suggest one of women's major strengths and to discuss its two-sided quality. I'll try to suggest briefly the process by which I think this strength has become a source of severe problems in past and present conditions. On the other hand, it can be the basis for women's more advanced development. The general topic has to do with the human necessity for intense ties to other people. For a shorthand term, I'll use the word, *affiliations*.

It is conveyed to a woman early in life that she is not to be a primary person, a person of her own intrinsic worth. She is to be different from the man or boy. He is granted the right to be a person who is supposed to develop himself according to the standards that society deems to be of value, who is supposed to become worthy.

Indeed, he has the obligation to do so and is assigned the primary right of working at that. If he doesn't succeed, he and society will consider him a failure. This goal becomes deeply ingrained.

A woman is not to be a primary person in this way—that is, in the way that says your main task and obligation is to attain these things which are held in highest value by this society. While this message to women is in one way destructive and can certainly be judged as an outrage for any society to say to any of its members, it obscures another whole issue. Even though women are deprived the right to male society's major "boon"—that is, development according to the male model—women's development is proceeding, but on another basis. One central feature is that women stay with, build on, and develop in a context of attachment and affiliation with others. Indeed, women's sense of self becomes very much organized around being able to make and then to maintain affiliations and relationships. Eventually, for many women the threat of disruption of an affiliation is perceived not as just a loss of a relationship but as something closer to a total loss of self.

Such psychic structuring can lay the groundwork for many problems. Depression, for example, which is related to one's sense of the loss of affiliation with another(s), is much more common in women, although it certainly occurs in men.

What has not been recognized is that this psychic starting point contains the possibilities for an entirely different (and more advanced) approach to living and functioning—very different, that is, from the approach fostered by the dominant culture. This approach values affiliation as highly as, or more highly than, self-enhancement. Moreover, it allows for the emergence of the truth: that for everyone—men as well as women—individual development proceeds only by means of affiliation. At the present time, men are not as prepared to know this. This proposition requires further explanation. Let us look at some common occurrences and then return to unravel this complex, but basic, issue.

Paula, a married woman with children, had been raised to make a relationship with a man "who would make her happy," and she had organized her life around serving his needs. Most of her sense of identity and almost all of her sense of value rested on doing so. She believed that Bill "made her valuable," even though, in fact, she ran a big household and responded to everyone's needs. As time went on, she felt some diminution in her central importance to Bill. As this feeling increased, she doubted her efforts to respond to and serve him and his interests, seeking to bind him to her more deeply. The actual things she did were not in themselves important to her. They counted only as they produced an inner sense that Bill would be attached to her intensely and permanently, and that this, in turn, would make her worthwhile. Thus, her successful life activity did not bring satisfaction in itself; it brought satisfaction only insofar as it brought Bill's interest and concern.

When Paula's efforts did not produce the result she was after, she became depressed, although she did not know why. She was filled with feelings that she was "so good," that she "didn't matter," that "nothing mattered." She felt Bill did not care enough, but she could not document convincing evidence for this feeling. He was fulfilling his role as a husband and father according to the usual standards; in fact, he was "a better husband than most," said Paula. This factor, of course, made her feel even more "crazy." She knew Bill cared, but she could not feel that he did somehow. She became persuaded then that there must be something terribly wrong with her. At the same time, none of the worthwhile things she did, provided her with any satisfaction at all.

It is important to note here that Paula was not "dependent," at least in the meaning usually implied by that term. In fact, she "took care" of Bill and their children in many ways. It is rather that Paula's whole existence "depended on" Bill's word that she existed or that her existence mattered.

Paula, like many depressed people, was a very active, effective person. But underlying her activity was an inner goal: that the significant other person—in this case Bill—must affirm and confirm her. Without his affirmation, she became immobilized, she felt like no one at all. What did it matter how she thought of herself? Such words had no meaning.

Even women who are very accomplished "in the real world" carry with them a similar sort of underlying structure. One woman, Barbara, holds a high academic appointment. In discussion she is a rigorous and independent thinker. Yet she struggles with an inner feeling that all of her accomplishment is not worthwhile unless there is another person there to make it so. For her, that other person must be a man.

Beatrice, a very successful business woman who could "sell" and persuade shrewd bargainers who intimidated many men, used to ask, "But what does it all mean if there isn't a man who cares about me? Indeed, when there was, she found her activities alive and stimulating. When there was not, she became depressed. All of her successes became meaningless, devoid of interest. She was still the same person doing the same things but she could not "feel them" in the same way. She felt empty and worthless.

Kate, a woman who was actively working for women's development, was sophisticated in her understanding of women's situation. At certain times she would become acutely aware of her need for others and condemn herself for it. "See, I'm not so advanced at all. I'm as bad as I always was. Just like a woman."

While Barbara and Kate did not become depressed, they felt the same underlying factor operating. Depression is used here only as an illustration of one end result of this factor. There are other forms.

All of the women cited offer hints of the role that affiliations with other people play for women. They suggest the kinds of problems that can result when all affiliations, as we have so far known them, grow out of the basic domination-subordination model.

According to psychological theory, the women discussed above might be described as "dependent" (seeking others "too much") or immature in several ways (not developed past a certain early stage of separation and individuation or not having attained autonomy). I would suggest instead that while these women do face a problem, one that troubles them greatly, the problem arises from the dominant role that affiliations have been made to play in women's lives. Women are, in fact, being "punished" for making affiliations central in their lives.

We all begin life deeply attached to the people around us. Men, or boys, are encouraged to move out of this state of existence—in which they and their fate are intimately intertwined in the lives and fate of other people. Women are encouraged to remain in this state but, as they grow, to transfer their attachment to a male figure.

Boys are rewarded for developing other aspects of themselves. These other factors—power or skills—gradually begin to displace some of the importance of affiliations and eventually to supersede them. There is no question that women develop and change too. In an inner way, however, the development does not displace the value accorded attachments to others. The suggestion here is that the parameters of the female's development are not the same as the male's and that the same terms do not apply. Women can be highly developed and still give great weight to affiliations.

This is one example of the way in which women are geared all their lives to be the "carriers" of the basic necessity for human communion. Men can go a long distance away from fully recognizing this need because women are so groomed to "fill it in" for them. But there is another side: women are also more thoroughly prepared to move toward more advanced, more affiliative ways of living—and less wedded to the dangerous ways of the present. For example, aggression will get you somewhere in this society of you are a man. It may get you quite far indeed if you are one of the few lucky people. But if you continue to be directly

aggressive, let us say in pursuit of what seems to be your rights or needs as a man, you will at some time find that it will get you into trouble too. (Other inequalities such as class and race play an important part in this picture.) However, you will probably find this out somewhat later, after you have already built up a belief in the efficacy of aggression; you already believe it is important to your sense of self. By then it is hard to give up the push toward aggression and the belief in its necessity. Moreover, it is still rewarded in some measure: you can find places to get some small satisfaction and applause for it, even if it is only from friends in the local bar, by identifying with the Sunday football players, or by pushing women around. To give it up altogether can seem like the final degradation and loss—loss especially of manhood, sexual identification. In fact, if events do not go your way you may be inclined to increase the aggression in the hope that you can force situations. This attempt can and often does enlarge aggression into violence, either individual or group. It is even the underlying basis of national policy, extending to the threat of war and war itself.

Instead, one can, and ultimately must, place one's faith in others. As social beings we are related to other human beings, in others' hands as well as in our own. Women learn very young that they must rest primarily on this faith. They cannot depend on their own individual development, achievement, or power. If they try, they usually are doomed to failure; they find this out early.

It is not that men are not concerned about relationships, or that men do not have deep yearnings for affiliation. Indeed, this is exactly what people in the field of psychodynamics are constantly finding—evidence of these needs in men as well as in women, deep under the surface of social appearance. This has been said in many different ways. One common formulation states, for example, that men search all their lives for their mothers. I do not think that it is a mother per se that they seek. I do think men are longing for an affiliative mode of living—one that would not have to mean going back to mother if one could find a way to go on to greater human communion. Men have deprived themselves of this mode, left it with women. Most important, they have made themselves unable to really believe in it. It is true that the time with their mothers may have been the time when they could really believe in and rely on affiliation. As soon as they start to grow in the male mold, they are supposed to give up this belief and even this desire. Men are led to cast out this faith, even to condemn it in themselves, and build their lives on something else. *And they are rewarded for doing so.*

Practically everyone now bemoans Western man's sense of alienation, lack of community, and inability to find ways of organizing society for human ends. We have reached the end of the road that is built on the set of traits held out for male identity—advance at any cost, pay any price, drive out all competitors, and kill them if necessary. The opportunity for the full exercise of such many virtues was always available only to the very few, but they were held out as goals and guidelines for all men. As men strove to define themselves by these ideas, they built their psychic organizations around this striving.

It may be that we had to arrive at a certain stage of "mastery" over the physical environment or a certain level of technology, to see not only the limits but the absolute danger of this kind of social organization. Or, it may be that we need never have come this long route in the first place; perhaps it has been a vast, unnecessary detour. It now seems clear we have arrived at a point from which we must return to a basis of faith in affiliation—and not only faith but recognition that it is a requirement for the existence of human beings. If we are to survive, the basis for what seem the absolutely essential next steps in Western history are already available.

A most basic social advance can emerge through women's outlook, through women putting forward women's concerns, and women have begun to do so. It is not a question of innate biological

characteristics. It is a question of the kind of psychological structuring that is encompassed differentially by each sex at this time in our development as a society of human beings—and a question of who can offer the motivation and direction for moving on from here.

The central point here is that women's great desire for affiliation is both a fundamental strength, essential for social advance and at the same time the inevitable source of many of women's current problems. That is, while women have reached for and already found a psychic basis for a more advanced social existence, they are not able to act fully and directly on this valuable basis in a way that would allow it to flourish. Accordingly, they have not been able to cherish or even recognize this valuable strength. On the contrary, when women act on the basis of this underlying psychological motive, they are usually led into subservience. That is, the only forms of affiliation that have been available to women are subservient affiliations. In many instances, the search for affiliation can lead women to a situation that creates serious emotional problems. Many of these are then labeled neuroses and other such names.

But what is most important is to see that even so-called neuroses can, and most often do, contain within them the starting points, the searching for a more advanced form of existence. The problem has been that women have been seeking affiliations that are impossible to attain under the present arrangements, but in order to conduct the search women have been willing to sacrifice whole parts of themselves. And so women have concluded, as we so readily do, that we must be wrong or, in modern parlance, "sick."

The Search for Attachment—"Neuroses"

We have raised two related topics: one is social and political, the other more psychological. One is the question of how women can find the forms based on affiliation by which they can act to enhance their development, and how they can build on this strength to effect real change in the real world. Secondly, until we accomplish this task—and along the way—can we understand more about the psychological events of our lives? Can we better understand why we suffer? At the very least, we may be able to stop undermining ourselves by condemning our strengths.

In the attempt to understand the situation further we can return to some of the women mentioned at the beginning of this chapter. They all expressed a common theme: the lack of ability to really value and credit their own thoughts, feelings, and actions. It is as if they have lost a full sense of satisfaction in the use of themselves and all of their own resources—or rather, never had the full right to do so in the first place. As Beatrice put it, there is the sense "that there has to be that other person there." Alone, her being and her doing do not have their full meaning; she becomes dry, empty, devoid of good feeling. It is not that Beatrice needs someone else to reflect herself back to her. (She knew she was, in fact, an excellent and accurate judge herself.) Her need seems even more basic than that. Unless there is another person present, the entire event—the thought, the feeling, the accomplishment, or whatever it may be—lacks pleasure and significance. It is not simply that she feels like half a person, but still able to take some satisfaction from her own half. It is like being no person at all—at least no person that matters. As soon as she can believe she is using herself with someone else and for someone else, her own self moves into action and seems satisfying and worthwhile.

The women referred to in this chapter are not so-called "syndromic," or other "immature" types of personalities. (Such terms, incidentally, may well require re-examination in relation to women.) In fact, they are very highly developed and able people who could not possibly be categorized in such a way. Nor, on a more superficial level, do phrases like "seeking approval" or "being afraid of disapproval" really cover the situation, although these factors play a part.

Their shared belief that one needs another person in a very particular way manifests itself in different ways for different people. In one form it leads readily into depression. The experiences of the women described here may thus provide some further clues to depression, may help us understand some aspects of it. While Paula and Beatrice did suffer depression, for other women there are different manifestations.

Everyone in the various psychological fields would probably readily admit that we do not fully understand depression (or fully understand anything else for that matter). Depression, in general, seems to relate to feeling blocked, unable to do or get what one wants. The question is: what is it that one really wants? Here we find difficult and complicated depressions that do not seem to "make sense." On the surface it may even seem that a person has what she wants. It often turns out, however, that, instead, she has what she has been led to believe she should want. (For many young middle-class women it was the house in the suburbs, a nice husband, and children.) How then to discover what one is really after? And why does one feel so useless and hopeless?

Beatrice's experience may offer some understanding on this point. In a roughly first period of self-exploration, she came to say that she sought to bind the important other person to her absolutely, and she wanted a guarantee of that bond. She was wanting but a passive, dependent, or helpless woman; but all of her activity was directed to this goal, which she believed she needed to attain. While she did not really need that kind of relationship, she was not convinced of it internally. (Often her activity in search of this goal took on a very forceful and manipulative character. Although the goal was usually pursued covertly and obscured from herself, it was felt very distinctly by those around her.)

Beatrice had developed the inner belief that everything she does feels right only if she does it for that other person, not for herself. Above all, she had lost the sense that the fulfillment of her needs or desires could ever bring her satisfaction. It is almost as if she had lost the inner "system" that registers events and tells her whether they make her happy or satisfied. The "registering" of what feels like satisfaction has shifted, it now comes only through her sense that she can make the other person remain in a particular kind of relationship to her. Only then can she feel strong and good. (In a more complex depression, like Beatrice's, it may not be the other person *per se* that one desires to bind but the image of the kind of relationship one believes one needs. For example, women whose children have grown up may not want to retain the individual children but they feel they must have the mother-child kind of relationship. In fact, one may not really need such a relationship, but the belief is strong, and a person who has spent a long time organizing her psyche on that basis will not easily relinquish the idea. Further, she has long since lost the belief that she can really have any other kind of relationship.)

Another facet of Beatrice's problem was the large amount of anger generated. To compound the problem, like many other women, she had great difficulty in allowing herself to recognize her own worth, much less express it. Even so, she was likely to become furious if the other person did anything that seemed to threaten to alter the bond. It seems clear that being in such a position is very conducive to rage. How could she not get angry at that other person to whom she had given so much control over her life? But Beatrice would become even more depressed because of the anger. In spite of her deep unhappiness, she could not really believe that there was any other possible way to live.

Like Beatrice, people liable to depression are often very active, very forceful; but their activity must be conceived of as benefiting others. Furthermore, it is organized around a single pursuit—seeking affiliation in the only form that seems possible: "I will do anything if only you will let me stay in this kind of relationship with you."

Some other aspects of depression may help to explain these points. It has long been recognized that there are so-called paradoxical depressions, which are most often observed in men. They occur after a man who has been competent receives a promotion or other advance that presumably should make him happy and even more effective. Such depressions may reflect the fact that the individual is forced to admit to increased self-determination and to admit that he, himself, is responsible for what happens. He is not doing it for someone else or under the direction of someone else. Women do not get promotion depressions so commonly because they do not get many promotions. Nonetheless, in Beatrice, who could accomplish prodigious feats as long as she had at least one person in a position superior to her, a very similar dynamic was at work. She would absolutely never let herself have the top job, although several had been offered to her.

A similar process may be at work in a phenomenon seen in psychoanalysis. It has long been recognized that people sometimes have what are called "negative therapeutic reactions." This means that they make a major gain and then seem to get worse after it. Bosnian has suggested that many of these reactions are in fact depressions and that they occur when a person has made a major step toward taking on responsibility and direction in her/his own life.¹ The person has seen that she/he can move out of a position of inability and can exert effective action in her/his own behalf, but then becomes frightened of the implications of that new vision; for example, it would mean the person really doesn't need the old dependent relationships. She/he then pulls back and refuses to follow through on the new course. Such retreats occur for men as well as women, but for women this situation is an old story, very similar to what goes on in life.

The significance for women of these two examples may be this: "If I can bring myself to admit that I can take on the determination and direction of my own life rather than give it over to others, can I exist with safety? With satisfaction? And who will ever love me, or even tolerate me, if I do that?" Only after these questions were confronted, at least to some degree, did Beatrice begin to ask the even more basic question: what do I really want? And this question, too, was not easy to answer. Beatrice, like most women, had been led so far from thinking in those terms. It often takes strenuous exploration, but usually it turns out that these are deeply felt needs that are not being met at all. Only at this point could Beatrice begin to evaluate these desires and to see the possibility of acting to bring about their attainment, and only then could Beatrice realize that there can be satisfaction in such a course. Moreover, it then became apparent that she did not need or want the kind of binding she had believed was so essential. Since the process described in this paragraph is so often thwarted, it seems obvious why women are set up for depression.

Many complications may come in to compound the situation for women, as they did for Beatrice. If one believes that safety and satisfaction lie in relationships structured in particular kinds of bonds, then one keeps trying to push people and situations into these forms. Thus, Beatrice was constantly working very actively at getting a man into this kind of relationship. She had a program for affiliation, the only one she was able to construct, but the program created her own bondage. This is why psychological troubles are the worst kind of slavery—one becomes enlisted in creating one's own enslavement—one uses so much of one's energies to create one's own defeat.

All forms of oppression encourage people to enlist in their own enslavement. For women, especially, this enlistment inevitably takes psychological forms and often ends in being called neuroses and other such things. (Men, too, suffer psychological troubles, as we all know) and the dynamic for them is related, but it does take a different path.)

In this sense, psychological problems are not so much caused by the unconscious as by deprivations of full consciousness. If we had paths to more valid consciousness all along through life, if we had more accurate terms in which to conceptualize (at each age level) what was happening, if we had more access to the emotions produced, and if we had ways of knowing our own true options—if we had all these things, we could make better programs for action. Lacking full consciousness, we create out of what is available. For women only distorted conceptions about what is happening and about what a person can and should be have been provided. (The conceptions available for men may be judged as even more distorted. The possible programs for action and the subsequent dynamic are, however, different.)

The very words, the terms in which we conceptualize, reflect the prevailing consciousness—not necessarily the truth about what is happening. This is true in the culture at large and in psychological theory, too. We need a terminology that is not based on inappropriate carryovers from men's situation. Even a word like autonomy, which many of us have used and liked, may need reworking for women. It carries the implication—and for women therefore the threat—that one should be able to pay the price of giving up affiliations in order to become a separate and self-directed individual. In reality, when women have struggled through to develop themselves as strong, independent individuals they did, and do, threaten many relationships, relationships in which the other person will not tolerate a self-directed woman. But, when men are autonomous, there is no reason to think that their relationship will be threatened. On the contrary, there is reason to believe that self-development will win them relationships. Others—usually women—will rally to them and support them in their efforts, and other men will respect and admire them. Since women have to face very different consequences, the word autonomy seems possibly dangerous; it is a word derived from men's development, not women's.

There is a further sense in which the automatic transfer of a concept like autonomy as a goal for women can cause problems. Women are quite validly seeking something more complete than autonomy as it is defined for men, a fuller not a lesser ability to encompass both the need for relationships and the need to pursue our own particular development. Thus, many of our terms need re-examination.

Many women have now moved on to determine the nature of their affiliations, and to decide for themselves with whom they will affiliate. As soon as they attempt this step, they find the societal forms standing in opposition. In fact, they are already outside the old social forms for new ones. But, they do not feel like misfits, wrong again, but like seekers. To be in this antiaffiliative position is not always comfortable, but it is not wholly uncomfortable either—and indeed it begins to bring its own new and different rewards. Here, even on the most immediate level, women now find a community of other seekers, others who are engaged in this pursuit. No one can undertake this formidable task alone. (Therapy, even if we knew how to do it in some near perfect way—which we do not—is not enough.)

It is extremely important to recognize that the pull toward affiliation that women feel in themselves is not wrong or backward; women need not add to the condemnation of themselves. On the contrary, we can recognize this pull as the basic strength it is. We can also begin, to choose relationships that foster mutual growth.

Other questions are equally hard. How do we conceive of a society organized so that it permits both the development and the mutuality of all people? And how do we get there? How do women move from a powerless and devalued position to full valued effectiveness? How do we get the power to do this, even if we do not want or need power to control or submerge others? It would be difficult enough if we

started from zero, but we do not. We start from a position in which others have power and do not hesitate to use it. Even if they do not consciously use it against women, all they have to do is remain in the position of dominance, keep doing what they are doing, and nothing will change. The women's qualities that I believe are ultimately, and at all times, valuable and essential are not the ones that make for power in the world as it is now. How then can we use these strengths to enhance our effectiveness rather than let them divert us from action?

One part of the answer seems clear already. Women will not advance except by joining together in cooperative action. What has not been as clear is that no other group, so far, has had the benefit of women's leadership, the advantage of women's deep and special strengths. Most of these strengths have been hidden in this culture, and hidden from women themselves. I have been emphasizing one of these strengths—the very strength that is most important for concerted group action. Unlike other groups, women do not need to see affiliation and strength in opposition one against the other. We can readily integrate the two, search for more and better ways to use affiliation to enhance strength—and strength to enhance affiliation.

For women to derive strength from relationships, then, clearly requires a transformation and restructuring of the nature of relationships. The first essential new ingredients in this process are self-determination and the power to make the self-determination a reality. But even before getting to this major issue, there are questions facing many women: "If I want self-determination, what is it I really *use* to determine? What do I want? Who am I anyhow?" The difficulty of answering these questions has sometimes served to discourage women. The discouragement occurs even in women who are convinced that there is something deeply wrong with the old way. Given the history that women's lives have been so totally focused on others, it is easy to see that such quest can bear a special urgency and come from a particularly hidden place in women. Many women are now undertaking this search. It, too, can take place with others, not in isolation, but also not just for others.

It is important here to note that this discussion of the importance of affiliations for women is by no means unrealistic. Nor is it a full discussion of any of the related, complicated problems, such as depression. Rather, it is an attempt to unravel a topic that requires much new examination. I hope that it will give rise to further discussion.

Women must continue to find more power and effectiveness—must continue on the path already begun, to be bold, imaginative, creative and strong. We start from a more advanced state in many ways. Only one of these has been suggested here. We have in a relatively short period, opened up visions of other possibilities. We already have the basis for a better way.

"PHYSICIAN HEEL THYSELF"

Preparation by Barbara Swoman

Note to all participants in the 1975 Conference on Women and Health: The ideas expressed in this paper are not yet completely formulated. Your suggestions are most welcome.

Many of us believe that "taking our bodies back"¹ or "reclaiming the means of reproduction"² is essential to a woman's revolution. While some feminists see economic discrimination as the most central inequity, others, including this writer, would place the biologic and reproductive issues first. The very word "hysteria" is derived from the Greek for wandering uterus. Even in this century, Freud said "anatomy is destiny" and Mussolini put it more starkly: "genius is genitals." Men have always said that because our bodies are different, they are less, and they have used

our biologic differences to legitimize all other forms of discrimination. Even in today's socialist countries, men make abortion available—or take it away—depending on their perceived population goals of the moment.

This writer became a health feminist in 1969 when she attended the annual meeting of the Association of American Medical Colleges. At that meeting, Dr. Frederick Robbins, a Nobel Prize laureate, and Dean of the Case Western Reserve University School of Medicine, stated to his colleagues:

"The dangers of co-operation are so great that we may have to use certain techniques of conception control that may entail considerable risk to the individual woman (italics mine)."³

Dr. Joseph Goldzieher, who gave dummy birth-control pills to Chicanos who had no knowledge that they were participating in a double-blind study (many, incidentally, were referred by San Antonio Planned Parenthood) has recently received a million dollars from AID, and another \$200,000 from HEW. Goldzieher was gratified by the FDA for failure to observe ethical protocols. Consequently, his drug-company funding dried up and he is now supported directly out of our tax dollars.⁴

When a PII-user has an impending blood clot, stroke, or pulmonary embolism, she may undergo a prodromal or warning period. Symptoms include severe leg or chest pains, coughing up blood, difficulty in breathing, sudden severe headaches or vomiting, dizziness or fainting, disturbances of vision or speech, weakness or numbness of an arm or leg. If she discontinues the PII, and is appropriately treated, the "accident" may be averted. In 1970, after a long struggle, the FDA agreed to place a warning to consumers in all PII packages. However, on June 23, 1970, a resolution opposing the warning was issued by the AMA House of Delegates, on the grounds that such a package insert would "confuse and alarm many patients." Instead, the warning was distributed to physicians to be given to PII-users at the time a prescription is issued. Few women have ever received it, and this writer knows personally of lives which were needlessly lost.⁵

The women's health movement has developed along two separate but usually co-operative channels. Some of us are working to reform the existing health care system, while others are setting up alternatives. Neither goes far enough. Women-run clinics do not have sufficient staff, funds, or access to technology to reach more than a small number of women. Reformers are usually thwarted, in this writer's experience. The PII warning was printed up, but not distributed to users. Goldzieher was censured by the FDA, but continues to get public money for his experiments on third-world women.

The feminist revolution has also been called the "sex-role revolution." Most feminists are dedicated to the abolition of artificial sex-role stereotypes, which, we feel, have crippled female and male alike. We want our daughters to be able to think, and our sons to cry. Nonetheless there is one difference between the sexes which is clearly not artificial. Only women get pregnant. As Sandra S. Tangen, of the U.S. Civil Rights Commission, has written in the *Population Dynamics Quarterly*:

"An accepted ethical principle forbids violating the bodily integrity of one person to secure the survival of another without the donor's consent. We would not consider it ethical to require a person to make his or her body available for organ transplants, experiments, or blood donations. Yet in the case of fertility, because continuation of the species requires that some women be fertile some of the time, all women are made subject to the social, legal, and political regulation of their reproductive capacity by others, mostly male.

"Bearing children involves some or all of the following costs: invasion of the women's body by the fetus; nine months of pregnancy; a period of restricted freedom while caring for the infant; risk of death, pain, disfigurement, major surgery (Caesarean) and permanent or temporary disability and disease; and social disabilities such as job discrimination against pregnant women and mothers. None of these costs are born by men, and none should be imposed unwillingly on anyone. It follows that the highest ethical priority for any intervention dealing with fertility is to secure to women the rights of personal security and freedom of

action by giving them control over their bodies and reproduction."⁶

On a gut level, this writer is now convinced that it is a most basic violation of our civil rights for the group that is not at any risk from reproduction (male) to control the group that is at risk (female). According to Barbara Ehrenreich and Dierdre English, male physicians used violence, including the murder of midwives, to stake out the field of obstetrics for themselves.⁷ As recently as 1971, this writer asked Dr. Michael Newton, Director of the American College of Obstetrics and Gynecology, why so few women had been allowed to enter his specialty. (Some 3% are female, as compared to 15% in pediatrics, psychiatry and general practice.) Newton replied that obstetrics is a strenuous specialty, and that "few women have the stamina for it."

It is true that many groups or classes have arbitrary amounts of power over other groups and classes. Teachers and students are one example, or managers and laborers. However, every teacher was once a student, and every laborer may aspire to enter management. But no male has ever conceived or borne a child. There is an absolute difference between the risk-bearer, or pregnant woman, and the males who wield control over her body, which is not paralleled in any other area of life.

Therefore, this writer proposes that we extend the phrase "abortion is no man's business" to "reproduction is no man's business." Or, as Aili Shulman puts it, "Let them get their big hands out of our vaginas." This writer asks all health feminists to seriously consider the following demands, and to join her in clarifying, expanding, and defending them:

FOUR DEMANDS

1. *Effective immediately, only women shall be admitted to obstetrics and gynecology residencies. Males who are currently in training may remain, as may those who are in practice. We do not wish to be punitive, nor place undue hardships on any individuals. Gradually, however, these fields will be returned to women. If men wish to reciprocally exclude us from the practice of urology they may do so. Our Constitution does guarantee the right of privacy. It has been suggested that some women might continue to prefer a male obstetrician. We do not wish to deprive such women of freedom of choice, and we shall kindly look the other way if a "civilly disobedient" group of male lay midwives, operating outside the official system and at little financial profit to themselves, should emerge.*

It is true that there are occasional males who are tender and profoundly empathetic toward women. This writer does not feel that a male is always and inevitably incapable of practicing obstetrics humanely. However, in some socialist countries a large number—perhaps a majority—of obstetricians are presently female. But, the smaller number of men in the field rise to the top, controlling hospital departments, research laboratories, ministries of population, and so on. Similarly, when men entered elementary school teaching in the United States, they quickly took over the administrative and policy-making positions, despite their smaller numbers. Thus, for the time being, simply having more women obstetricians would not bring about sufficient improvement. Men who get hold of a new technology too often behave like little boys with pop guns—and the long range consequences be damned. Our bodies and our babies are too precious to continue allowing this experimentation. We profoundly regret that our efforts to educate male physicians to our needs and requirements as women and as patients, have by and large been dismal failures.

2. *Effective immediately, no more federal monies will be awarded to men for any kind of research into the female reproductive system. Again, we do not wish to work any hardships on anyone, and existing commitments will be honored. There are many women scientists who have become feminists, and would like to be doing research that is pertinent. For the next five years, all new grants for reproductive research will be channeled toward training qualified women in reproductive biology. Men who have an interest in reproductive biology will be encouraged to develop male contraceptives, perfect sperm banks, etc.*

3. *Effective immediately, the establishment and administration of laws concerning female reproduction, abortion, and*

sterilization, shall be removed from male courts and legislative systems. An all-female agency, modeled after the NRE, FCC, FTC, or Atomic Energy Commission, shall handle such matters. This agency might be called STERUP. (Stop Irresponsible, Rip-offs of People.) A division of the agency will provide free advocates and legal aid for all women seeking help with any reproductive issue or who have experienced malpractice in any form.

4. *Effective immediately, the United Nations and the United States will not sponsor nor participate in any international population activity or conference unless women are represented in proportion to their numbers in the population of every participating nation. The United States will award no funds to other nations for research or other population activities, unless women are represented on all projects in proportion to their numbers. Each project will be individually considered, and proof of compliance must be submitted.*

Originally this demand was for all-woman representation at population conferences, etc. However, many health feminists do feel that men, as fathers and as co-inhabitants of a crowded planet, are entitled to a voice on general population issues, not immediately effecting women's reproductive health.

In conclusion, this writer would not wish to advocate any policies that are contrary to the ERA. She has discussed these proposals at some length with three knowledgeable lawyers, Nancy Wechsler, Kris Glen, and Maria L. Marcus. Ms. Wechsler fears that the proposals are contrary to the ERA. However, Ms. Glen and Ms. Marcus maintain that they are not. Glen feels that these demands can be construed as part of our right to privacy, like having women's bathrooms attended only by women, which will be continued under the ERA. Glen also believes that feminism can be claimed as a BFOQ (bona fide occupational qualification) for the practice of obstetrics and gynecology, the performance of reproductive research on women, and the other issues. Defending the BFOQ construction, Glen states men are socialized to think of women's bodies in certain destructive ways, and that their record of past and present atrocities speaks for itself.

Marcus, who was an author of the New York City Bar Association's influential report on the ERA, points out that the ERA would permit distinctions between the sexes, when there are "characteristics . . . which are present in all of one sex, and none of the other." The Bar Association Report explicitly states:

"The Equal Rights Amendment, however, would permit sex-based distinctions only when they are grounded upon physical characteristics unique to one sex. This provides a readily ascertainable, consistent and objective standard."⁸

Feminists sense that we are the history-bearing group of our time, and that it may fall to us to save our species.⁹ Chemical birth control methods may have latent effects on the gametes and germ cells, but these crucial long range questions are not even being studied.¹⁰

A section of the Haggadah, or Jewish Passover Service, states:
 Leader: The struggle for freedom is a continuous struggle
 For never does man (sic) reach total liberty and
 opportunity.
 Assembled: In every new age, some new freedom is won and
 established.
 Adding to the advancement of human happiness and
 security.
 Leader: Yet, each age uncovers a formerly unrecognized
 servitude.
 Requiring new liberation to set man's (sic) soul free.
 Assembled: In every age, the concept of freedom grows broader.
 Widening the horizons for finer and nobler living.
 Leader: Each generation is duty-bound to contribute to this
 growth.
 Else mankind's (sic) ideals become stagnant and
 stationary.¹¹

In addition to the three lawyers mentioned earlier, Ms'es Wechsler, Glen and Marcus, Esqs., this writer wishes to thank other feminists who have helped contribute to, or clarify these

proposals, especially Pauline Bart, Kacy Cook, Ann Fuller, Mary Howell, Helen Marleskind, and Alia Katz Shulman. In its present form, responsibility for the content of this "manifesto" is entirely the writer's own. However, she is hopeful that many other women (and interested men) will contribute to the further clarification of these ideas, and that, eventually, a petition may be circulated and actions started to gain these ends.

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NOTES

1. Margaret Lazarus' phrase.
2. Pauline Bart's phrase.
3. See Seaman, Barbara, *The Doctors' Case Against the Pill*, N.Y. Peter H. Wyden, 1969.
4. See Seaman, Barbara, *Free and Female*, N.Y. Coward, McCann & Geoughgan, 1972. Fawcett paperback. Also available in Spanish as *Remolva y Libro*, Editorial Grijalbo, S.A. Mexico, D.F. Also see *ME Magazine*, June, 1975, P20 article by Barbara Seaman.
5. The full warning is reproduced in *Free and Female*.
6. *Population Dynamics Quarterly* (Vol. 11, #4, 1974), published by the Interdisciplinary Communications Program of the Smithsonian Institution, Washington, D.C.

7. *Witches, Midwives and Nurses*, Feminist Press, Old Westbury, Long Island, New York, 1972.
8. The full report of The Equal Rights Amendment may be obtained from: The Association of the Bar of the City of New York, 42 West 44th Street.
9. Daly, Mary, *Beyond God the Father*, Boston, Beacon Press, 1973.
10. Paper delivered by Sheldon Segal to the FDA, January 1975. Segal stated:

"The use of synthetic sex hormones has grown to an extent that makes this class of drugs a significant part of the chemical environment. The under-thirty generation has been raised on beef fattened with estrogen-laced feed, lambs born of estradiol-synchronized ewes, chickens caponized with estrogen paste or pellets. They are the first generation to include a large percentage of post-pill babies born to mothers who used steroidal contraception prior to planned or unplanned pregnancies and are themselves prodigious consumers of steroidal estrogens and progestins on a steady basis...steroidal and non-steroidal sex hormones...could reach and effect the gamete, embryo, or fetus...one serious hazard—the use of high doses of stilbestrol during pregnancy—has been disclosed."

11. *Haggadah for the American Family*, English Service with Directions, written by Martin Berkowitz, Rabbi, Temple Adath Israel of the Main Line, Merriion, Pa.

CONFERENCE REPORTS

CURRENT ISSUES

Introduction

by Judy Herman and Sandi Altman

Women are subject to massive surgical assault comparable to rape in its scope and effects. We are only beginning to recognize the dimensions of this problem and the damage that has been done. In a sexist society our reproductive organs quickly become superfluous; we become prey. A little bleeding becomes the occasion for removing the uterus; a lump in the breast and the breast is cut away. If we have too many children (and who is to say how many are too many?), we are pressured into having our tubes tied. As always this is especially true for poor women and women of color. Control of our bodies requires control of the knife.

We have fought hard for free access to one surgical procedure—abortion. We have won a partial victory, and that is something to be proud of. But the victory is far from being secure, far from being complete. While this service remains inaccessible to women who want and need it, other medical procedures which we neither need nor want are being forced upon us.

Who is responsible for this? It is not hard to recognize the surgeon's greed, or the indifference and prejudice of the medical profession. It is not hard to identify the familiar enemies of the abortion struggle: the "right-to-life's" and the Catholic hierarchy. But the responsibility lies elsewhere as well. Ultimately, it lies with our entire political system, which is based upon profit and military conquest. Within this system we are not and can never be much more than breeders, trophies, or prey.

This is particularly clear in the case of forced sterilization. Although this practice is carried out by the medical profession both in the Third World and in the United States, it does not originate within the medical profession and is carried out despite the opposition of the Catholic Church. This practice originates within and is encouraged by the population control establishment.

To say this is to create controversy among feminists. Many women who have fought hard for abortion rights, or who have been active in organizing for consumer control of health care, do not recognize the concept of an imperialist ruling class. Or if they do, they are not convinced that it is necessarily our "enemy." This

is understandable, since population control groups have at times been our ally, particularly in the abortion fight.

Many women at the Conference were offended by criticism of agencies such as International Planned Parenthood. Hadn't these people been our friends? Isn't it true that the world is overpopulated? Wouldn't poor women really be better off if they had fewer children? Aren't the population control agencies just trying to help them?

Many of us do not believe this. We believe that the population control establishment mainly represents the interests of the American ruling class, which seeks to maintain the existing power structure. It is important to remember this, even when the population control groups use our language and appear to be "on our side." Third World women have repeatedly called our attention to this reality.

I. The Politics of Abortion

panelists: Pam Lowry, National Abortion Rights Action League, Boston, Mass.; Elizabeth McCord, Planned Parenthood, Newton, Mass.; Debra Law, Feminist Women's Health Center, Oakland, Calif.; Dorothy Brown M.D., Nashville, Tenn.

moderator: Judith Herman M.D., Somerville Women's Health Project, Somerville, Mass.

A. Legal Issues Lowry

The right to abortion, conferred by the 1973 Supreme Court decision, is far from secure. Almost immediately after the decision well-financed, so called "right-to-life" groups were organized for the purpose of invalidating the Supreme Court decision. They have focused mainly on the Congress and have been active in the courts (as in the Edelin trial). Initially, this lobby promoted a number of "fetal rights" amendments to the Constitution, which would declare a fetus to be a person with full legal rights from the moment of conception and would prohibit abortion with few exceptions. These amendments appear to be too reactionary for the Congress and have little chance of passage. However, the right-to-life forces have developed a fall-back position which has much better chances of succeeding. This is the "states' rights" position. If a states' rights amendment is passed, it would nullify

the Supreme Court decision by giving jurisdiction over abortion to the states. In practice this once again would outlaw abortion in many states. The states' rights amendment appeals to many politicians in Congress who would like to avoid dealing with this issue. Continued vigilance and organizing is necessary.

B. Availability of Abortion (McCard)

Although legal, abortion is still unavailable in many parts of the country. Most abortions are done in urban centers in highly populous northern states. New York and California still provide over half of all abortions. In 14 states the rate of abortion is less than 5/1000 births, while in Washington, D.C. the rate is 233/1000. No legal abortions were performed last year (1974) in Louisiana, Mississippi, or North Dakota.

As of 1974, there were 1300 abortion providers in the country. Seven per cent of these providers did 57% of all abortions. Only 17% of all public hospitals do any abortions. This is particularly significant for poor women, since public hospitals are often their only source of medical care. In Massachusetts, abortions are done in the two largest cities, Boston and Springfield. This is typical of most states.

Predictably, young and poor women face the greatest difficulties. Parental consent is almost uniformly required for minors, though some providers are not too strict about proof of age if the young woman seems mature and confident of her decision. Many states will not provide Medicaid payments for abortions except under limited conditions. New Hampshire Medicaid pays for no abortions regardless of the reason. Repeated efforts have been made in Congress to forbid the use of federal funds to pay for abortion. So far, these efforts have not been successful. However, HEW has recently proposed new guidelines under which the Federal Government would reimburse states for Medicaid payments at a rate of 90% for sterilization but at only a 50% rate for abortion. This pressures poorer women to be sterilized rather than have abortions.

Information about abortion is still hard to get. Right to life billboards proclaim that abortion is murder, while advertising of abortion services usually is restricted from public transportation, major newspapers, and other mass media. ATF has for years refused to list abortion in the yellow pages. Many women still do not know that abortion is legal.

The right to abortion remains a theoretical right for many women in this country.

C. Feminist Alternatives (Law)

The legal status of abortion and its practical availability ultimately depend on the country's population control policies. Abortion rights may be granted or withdrawn depending on our government's perceived requirements for workers and soldiers. This has proved true not only in capitalist countries, but in socialist countries as well. In the Soviet Union, abortion was legalized with the revolution, but outlawed in the 1930's when the country was preparing for war. More recently, several eastern European countries (e.g. Hungary, Rumania, Czechoslovakia) have reversed or restricted previously liberal abortion policies because of concerns about low birth rates. In the United States our governing class is presently concerned about overpopulation, so abortion is therefore permitted. But this situation could easily change.

Our only protection from the vicissitudes of population policy is to have the technology of reproductive control in our own hands. We need to have our own abortion facilities and to develop our own research. Women-controlled abortion facilities provide a financial base for other women's health-organizing activities and a focus for research on women-controlled techniques such as menstrual extraction.

In Oakland, the opening of a women-controlled abortion facility had an immediate and practical effect on abortion care. Before its opening, abortion required a three-day hospital stay at a cost of \$500.00. Now, the usual time spent in the clinic for this procedure is 5 hours, and the standard price for an abortion in Oakland is \$150.00.

If abortion once again should be outlawed, it is likely that some women-controlled clinics would continue to do abortions, either publicly, as an act of civil disobedience, or underground.

B. The Politics of Population Control

panelists: Linda Gordon, *Assistant Prof. of History, U. Mass., Boston; Helen Rodriguez-Trias M.D., Attending Pediatrician, Lincoln Hospital, Bronx, N.Y.; Bonnie Mass, author Political Economy of Population Control in Latin America, Cambridge, Mass.*

moderator: Judith Herman M.D., *Somerville Women's Health Project, Somerville, Mass.*

A. History (overview)

Both birth control and population control are ancient. The former is technology used by individuals to limit child-bearing. The latter refers to a social program of reducing births. This distinction is vital.

Birth control became illegal because of religious and, above all, male-supremacist ideology in modern times. The women's rights movement of the 19th century produced a "voluntary motherhood" movement. Its principles were feminist, intending to increase women's individual autonomy, without any population control ideology. It was a movement of middle class women, but evidence shows that women of all classes used birth control and wanted better birth control.

Meanwhile, the development of capitalism produced a revived population control movement associated with the name of Malthus. Its purposes were to increase the standard of living of the working class without having to allow any redistribution of wealth, and to convince the poor that their poverty was their own fault, due to their irresponsibility in having too many children. In the late 19th and early 20th centuries, with the spread of imperialism, Malthusian thought developed into an ideology called "eugenics." This was an explicitly racist theory which described light-skinned people as "superior" and people of color as "inferior stock." According to this theory, since poverty is an inherited sign of genetic inferiority, the way to improve the human condition is to encourage births among the better human stock and to discourage breeding among the inferior stock. In the U.S. this ideology was invoked against immigrants and blacks; in the colonies, it was invoked against colonized peoples. Eugenics initially had nothing in common with feminism, nor indeed with any vision of human liberation.

Around 1914, socialists in the U.S. began to build a feminist, working-class oriented birth control movement. Their tactics were direct action and civil disobedience: setting up clinics and giving out contraceptive information in defiance of the law. This movement was eventually destroyed. Its destruction was partly due to the general right-wing reaction in the U.S. following World War I. But it was also due to the hostility and indifference of the male-dominated left, where reproductive issues were never given major priority. Cut off from their support on the left, the women most committed to birth control, such as Margaret Sanger, increasingly sought support from conservative sources: racist eugenicists and male professionals, especially doctors. As a result of this opportunistic merger, birth control became almost indistinguishable from population control.

In the 1960's, the movement for birth control again became a popular movement, led by radical feminists. As in the past, the same possibilities for cooptation of this movement exist in the present. Women's issues are still denigrated in the male-dominated left, while imperialist agencies are adopting the slogans of women's liberation to promote population control, particularly in the Third World. We must bear in mind that they are not our allies, and do not represent our real interests.

B. The Case of Puerto Rico (Rodriguez-Trias)

U.S. government population control policy is an important aspect of imperialist policy. It is designed to maintain domination of working people both within the borders of the U.S. and without. This is particularly so in the Third World.

Puerto Rico is a laboratory for U.S. population research and policy formation. Historically, there have been too many people on the island for the purposes of its ruling class, and emigration has

been promoted for many years. In the last 15 years, in accordance with a plan to reduce the island's population by one million people, 35% of the women of childbearing age have been sterilized. This was accomplished by making abortion illegal and reversible methods of birth control expensive and hard to get, while sterilization is available free at government-sponsored clinics throughout the island. Women are frequently pressured into consenting to be sterilized during labor or when applying for social services. Many are not told that the procedure is irreversible. For those desiring any form of birth control, there is virtually no other choice. This policy has been carried out in spite of the Catholic Church's opposition to sterilization, which reveals something of the relative power of the Church and U.S. imperialism.

What happens in Puerto Rico presages what is likely to happen in the U.S. According to *Family Planning Digest*, an HEW publication: "As U.S. professional attitudes change, it is possible that we may see sterilization become as important in family planning in the fifty states as it already is in Puerto Rico."

As feminists we must not confuse the need to control our bodies with population control policies as espoused by the vast officialdom. The ruling class has no such confusion and will fight against abortion rights while endorsing and subsidizing sterilization. The case of Puerto Rico illustrates this clearly.

Without an end to imperialism, there is no way that women's rights can become real. As with abortion, each gain we make can be used for oppressive ends if controlled by ruling class interests. Health care for women, including services which deal with our reproductive functions, must be developed within the context of high quality comprehensive care for ourselves and our families, care which is under our own control. The struggle for sterilization guidelines, informed consent, etc., is an important form of political education.

C. Population Control and the Women's Movement? Mass

There is strong documentary evidence linking the major agencies of world population policy, such as A.I.D., the Population Council, and International Planned Parenthood, to the American industrial ruling class, particularly that portion which controls the multi-national corporations. The prominence of John D. Rockefeller III in international population planning activities typifies this connection. These agencies are conducting a major propaganda campaign to convince us that world poverty is not due to maldistribution of wealth, but to overpopulation.

Because the women's liberation movement has failed to identify U.S. imperialism as the key oppressor, we can easily be coopted by the population control establishment. To focus solely on abortion rights is to abdicate from the fight for broader survival needs of women. To focus solely on self help and alternative clinics is to avoid the broader struggle to control existing health care institutions. Women's liberation can occur only in the context of a world-wide struggle for a new social order.

III. Unnecessary Surgery on Women

panelists: *Irina Posner, CBS News, New York; Barbara Swanson, author, New York.*

moderator: *Norma Swanson, Boston Women's Health Book Collective.*

As compared to Great Britain, the United States has twice as many surgeons in proportion to its population. Not surprisingly, this country also has twice as many operations in proportion to its population. One of the most frequently performed operations is hysterectomy.

Each year over half a million hysterectomies are performed. The incidence of this operation is steadily increasing and ranks second only to appendectomy among operations performed on women. At the current rate, 45% of all women can expect to have this operation before they reach the age of 70. Only 20% of these procedures are performed because of cancer. Several independent studies have concluded that over one-third of all hysterectomies are unnecessary. Out of approximately 220,000 unnecessary hysterectomies performed each year, 1100 deaths result.

Our fee-for-service medical system provides doctors with a

great incentive to recommend surgery. If an operation is performed, the surgeon, anesthesiologist, and hospital all make money. Mandatory review of recommendations for surgery is incorporated into some union health plans (such as the United Mine Workers and the Teamsters Union). In some cases this has reduced hysterectomy rates by as much as 85%. A second opinion from a qualified specialist who does not stand to gain from the outcome was strongly recommended by the panelists whenever surgery is advised.

A videotape on hysterectomy, shown at the Conference, is available from Irina Posner at CBS News.

One major focus of this workshop was the unnecessary risk from anesthesia associated with unnecessary surgery. Workshop participants shared experiences in trying to evaluate anesthesiologists and anesthesia services in hospitals, suggesting that women should ask for much more direct information about anesthesia and anesthesia techniques. Discussion included not only hysterectomy, which was the focus of the workshop, but also biopsies of breast lumps, 90% of which are benign. It was pointed out that the general anesthesia which has been routine for the breast biopsy operation often could be avoided by aspiration or needle biopsy procedures. Also, if surgical biopsy were necessary, it could be done under a local anesthetic, thus eliminating the risk of general anesthesia (see 1976 edition of *Our Bodies, Ourselves* for details).

IV. Breast Cancer

panelists: *Mary Costanzo M.D., Oncologist, Tufts Univ. Medical School; Oliver Cope M.D., Prof. of Surgery emeritus, Harvard Medical School.*

moderator: *Judi Adams, Tomerville Women's Health Project.*

Breast cancer is the most common cancer in women, affecting one out of 15 women in this country. It is uncommon in women under 30, and the incidence increases steadily with age.

Early first pregnancy and early menopause decrease the risk of breast cancer. The risk is also lower in many Third World countries than in western, industrialized countries.

Individuals who have a family history of breast cancer, who have an early menarche and late menopause, and who are exposed to high doses of steroids in their diet are at a higher risk for breast cancer.

Regular breast self-exam is of major importance in cancer detection. Most cancers are originally discovered by the woman herself, not by a doctor. The earlier a cancer is detected, the greater the likelihood of cure.

The proper treatment of breast cancer is controversial. At present most surgeons recommend radical mastectomy for breast cancer. In this procedure the entire breast is removed along with the underlying muscles and the lymph nodes in the armpit. Usually this is done at the time of biopsy if a frozen section shows cancer. This means that a woman entering surgery with question of breast cancer does not know if she will wake up in a few minutes with a small incision in her breast, or in a few hours with her breast gone. Radical mastectomy was given an enormous amount of publicity this year when both the president and vice-president's wives underwent this procedure.

Both panelists challenged this practice. Many breast cancers grow slowly. If a woman discovers a lump in her breast, there is not necessarily need to rush immediately into surgery. A number of diagnostic procedures, such as mammography or thermoradiography may be performed first. If these are not conclusive, a biopsy may be performed under local anesthesia, when the lump is removed and examined microscopically. This technique is more thorough and accurate than the frozen section. If cancer is found, further tests should be performed to determine whether there is evidence of cancer elsewhere in the body. After all this information is in, the woman and her doctor decide upon the optimum treatment method. The existing major choices include surgery, drugs, and radiation. Resistance to abandoning radical mastectomy within the medical profession is not based on proof of its superior outcome, but upon tradition and upon the surgeon's reluctance to include the patient in decision-making about her treatment.

SELF-HELP, PREVENTIVE MEDICINE AND HEALTH EDUCATION

Coordinated by *Andee Rubin*

The subgroup organizing workshops in these areas acted in many respects as a catch-all for topics not covered by other subgroups. Although those of us in the subgroup had political views of health care, we expressed primarily one political philosophy through the workshops, namely that *people should have information*. In several planning sessions we discussed the fact that knowledge often leads to action, but our main focus was on the information women needed to have.

First, we'll discuss our process of organizing the workshops. Second, we'll talk about the workshops themselves, including a brief description of each.

Fortunately, our group worked well together. We had no designated leader, though, as in most groups, a few of us took the responsibility for initiating meetings and telephone trees. The 12 or so of us included medical students, a nurse practitioner, and women working in non health-related fields who had strong "extra-curricular" interest in health. We agreed upon topics as a group. After that, each workshop became the responsibility of one person, who was to decide on a format, find workshop leaders, and communicate with them about our expectations for the workshops. Often, we exchanged ideas, names of people, and resources. Our group's small size and the fact that tasks to be done could be treated fairly independently probably contributed to our successful process. (Remember: finding meeting times convenient to most women is a very given: Conference planning group was consistently a problem.)

As we worked together, some of the basic concerns of our subgroup and the Conference Planning Group emerged repeatedly. In choosing topics, we wanted to maintain an emphasis on women and health, but we sometimes had difficulty defining boundaries. Women's health certainly included prenatal care and birth, but did it include pediatric care? (One speaker doing a workshop on Primary Care at Home objected to emphasizing children's diseases, because she felt that this reinforced women's roles as mothers. We countered that it was a fact that women *did* take care of their kids' health problems and that it was certainly better for them to be well-informed.) Should we include workshops on innovative or traditional medical techniques more commonly used by women but not only applicable to women? (We did decide to have a workshop on massage, led by an all-women massage collective, and one on herbal medicine, a topic which was embraced almost exclusively by women, both in terms of tradition and new practitioners.) What about covering all aspects of nutrition? (We decided to concentrate on nutritional problems affecting women: pregnancy and nutrition; psychological aspects of obesity for women; etc. Nutrition and dental health was included primarily because we had been contacted by a woman dentist—of which there are few—who was very enthusiastic and turned out to be quite popular at the Conference.)

Before communicating our expectations to speakers and workshop leaders we had to talk among ourselves about an issue central to the whole Conference: the involvement of community women. Though the Conference had been planned, by and large, by students, women's health activists, and professionals (both activists and non-activists), we wanted to involve all women of the Boston community: office workers, factory workers, homemakers, mothers, women of Third World communities. The larger Conference Planning Group dealt with this by sending flyers to lists of women supplied by sources such as labor unions, Third World women's organizations, etc. Despite this effort, our subgroup expected that the majority of attendees would be rather well-versed in women's health matters and not, for the most part, representative of all women in the Boston community. Thus, we asked our speakers to be prepared to speak at a somewhat sophisticated level, but to be ready to go over basics at the audience's request.

As it turned out, workshop participants did know quite a bit (many were community health center workers or long-time followers of the women's health movement), often contributing as

much as the workshop leaders. In the birth control workshop, after general discussion of not-yet-proven birth control methods women had tried or heard of, women established a "high context information exchange" (see Resources) for further gathering and dissemination of data.

One of the major failures of the whole Conference was, in fact, its failure to attract community women. One of our workshops (on organizing a Women's Community Health Day, led by Eleanor Palles, a physician's assistant) addressed this problem specifically. Workshop participants, many of whom had run women's health fairs, made the following points: that it's important to "go slow on politics" and to take into account at all times the community's ethnicity and culture; that local agencies such as the Red Cross, state and city health departments, the American Cancer Society, Planned Parenthood, and TWCA's may provide useful resources (often free) and free publicity; that follow-up to a women's health day is important (the event should become annual, local clinics and labs should be prepared to take care of women inspired by the fair to seek certain medical care, etc.). Though it is sometimes difficult to work with established agencies without necessarily becoming identified with their politics or policies (often quite different from our own), it is possible to do so and often worth the risk.

Following are brief descriptions of other workshops organized by this subgroup:

Women and Nutrition. Panelists: Wendy Mudgey (obesity program at a Boston hospital nutrition clinic), Maggie Levin (author of *Maggie and the Beautiful Machine* and creator of a TV show of the same name), Ruth Palumbo (a Boston hospital nutrition clinic—specializes in pediatric, perinatal and maternal nutrition), and Carol Palmer (assistant professor of nutrition at a Boston dental school).

The panelists discussed diets, methods of losing weight, what constitutes "good nutrition" (including the special nutritional needs of pregnant and nursing mothers), the role of sugar in the formation of dental caries, and the importance of nutritional status at the time dentures are put in the mouth.

Birth Control: Facts and Controversies. Workshop leader: Leslie Corwin. This workshop quickly opened up into a general discussion when it became apparent that most of the women in the group were birth control counselors on the lookout for new information. The pill and IUD were discussed in depth. It was agreed that it's probably a useless precaution to go off the pill for 2 months every few years as it's not long enough to test anything and does not do much to prevent the kind of damage the pill can do if it's going to. The general consensus about the pill was pretty negative, and the feelings about the IUD were not much better. The Copper T, which everyone had their hopes on as causing a much higher infection rate than expected. One new development brought up at this workshop and the workshop on Menstruation was the use of Vitamin C for birth control. Women from the Detroit Women's Health Center reported cases of women who had conceived and not implanted after taking 6 grams of Vitamin C every day (that is twelve 500-milligram pills spaced throughout the day) for the five days before their period was due. (For more on this see recent issues of *The Monthly Extract*—see "Resources.")

Menstrual Extraction. Workshop leader: Lorraine Rothman. This workshop combined both discussion and demonstration. The leaders defined Menstrual Extraction as a technique used by a woman who has been participating in an advanced self-health group. The decision to have a period extracted is arrived at through group discussion, and procedure is performed in a group setting on the first day of a woman's period. The device used, a Delfium, was invented by Lorraine Rothman. Its construction makes it impossible to pump air back into the uterus and allows the cannula to move in the os as little as possible. Because the vacuum created is very small, the extraction may last as long as 45 minutes. After some discussion one of the women demonstrated the technique.

The workshop emphasized some important political points. Menstrual extraction is research on women done by women. No one really knows what the long term effects of the procedure are;

reports so far have claimed that cramps, tension and headache disappear when a woman's period is extracted, but there may be bad effects as well. What is important is that the women doing menstrual extraction are aware of the risks that they are taking and are willing to participate in this experiment which they themselves control.

Menstruation. Theory and Practice (originally titled: *Menstrual Problems*). Workshop leaders: Esther Rome & Emily Culpepper. At the beginning of the workshop Emily's *Period Piece*, was shown (see Resource section). It explores attitudes, images, and experiences about our periods. After the film we discussed attitudes and problems relating to menstruation, both being inter-related. Discussion focused on the following: the inadequate research on menstruation (done by patriarchal medicine) and the need for more research by women; quotes from medical textbooks which illustrate the attitude towards menstruation as sickness and/or defect; the need for a positive evaluation of the menstrual experience based on our experience; the importance for each woman of knowing her own cycle—what does and doesn't seem usual or normal for her; ways of coping with the premenstrual tension syndrome and with menstrual discomfort (dysmenorrhea)—see below; feelings about menstruating while on birth control pills; feelings about amenorrhea; ways to deal with menstrual fluid: sanitary napkins, tampons, Tassaways, plastic cups, small-size diaphragm (with K-Y jelly), and natural sponge (lined with dental floss for easier removal); and theories about cramps.

During the discussion women talked about the importance of being flexible about how our periods fit into our lives and of not setting up our own arbitrary "right think"—not to glorify either extreme of always setting aside special rest time, versus totally ignoring our periods. Menstrual and premenstrual time is a culturally approved time for women to be "sick," bitchy, angry, etc., a time to express "unfeminine" emotions. Cramping sometimes indicates physical problems, like endometriosis, which are often ignored by the medical profession.

Women talked about how menstruating while "on the pill" was not a "real" period, just a chemically induced bleeding.

Several women had not had periods (amenorrhea) for over a year or more. They talked about their sense of having lost a familiar part of themselves and were surprised by this feeling. They even would rather have cramps than no period at all. They also felt a lack of support for dealing with this issue.

The following is a compilation of all the remedies for dysmenorrhea collected so far. This is *not* a recommendation for safety or efficacy! The most often recommended items are starred (*).

*Take dolomite calcium or calcium and magnesium tablets a few days before your period. See Adele Davis for amounts.

Reduce intake of certain foods: refined foods, especially sugar and white flour, also caffeine, most common in coffee and cola drinks.

If you have a potassium depletion the following foods are good to eat: very ripe bananas, fresh orange juice, legumes (beans, peas, peanuts), bran, seaweed, blackstrap molasses, brewer's yeast.

Eat a vegetarian diet.

Eat brewer's yeast for B vitamins and calcium.

Drink tea made of any of the following:

Banacha twig and ginseng, Banacha twig and tamar, Black hawk, Catnip, Dandelion, Juniperberry, Ladies mantle, Nettle (diuretic), Pennyroyal, Peppermint, *Raspberry leaves, Spicebush, Wild sage, Yarrow (If flowering too hard—not for use during pregnancy).

Take an over-the-counter pain killer, e.g., aspirin.

Smoke or eat marijuana.

Take estrogen or progestogens (cf. Dalton, *The Menstrual Cycle*).

Take tranquilizers.

See a psychiatrist or therapist.

Have menstrual extraction done.

Have acupuncture done.

Use self-hypnosis.

Take a warm to hot bath.

Sit in a cool bath until the water warms up.

Generally increase the amount of exercise you do. Yoga or karate may be particularly helpful. Symptom reducing exercises can be found in H. C. Maddux, *Menstruation*, pp. 128-143. (The rest of this book is not recommended.)

Carlf up with knees to chest, put a hot water bottle or hot salt pack on your stomach or lower back.

Use a compress made from fresh grated ginger, wrapped in cheesecloth and heated in water to boiling. Apply to abdomen.

Speed up flow by taking a steam or sauna bath or having an orgasm.

Do deep intestinal massage.

Do pelvic floor muscle contractions (e.g. Kegal exercises) to increase circulation in the pelvic area.

*Pinud lower back and buttocks, especial coccyx area, as hard as is comfortable. Lean forward to do it on yourself or have someone else do it.

*Do menstrual massage described below.

*Press with fingers on either side of lumbar vertebrae, along the top ridge of the pelvis and diagonally across the buttocks. (See diagram.)

For remedies used by Chinese barefoot doctors see: *A Barefoot Doctor's Manual*, pp. 485-7. (Published by the U.S. Government Printing Office, 1974, \$9.75. Ordering number: HE20 3708 B21).

The following herbs are supposed to be emmenagogues (i.e., they promote menstruation. This list does not imply efficacy or safety). Lovage, Blue cohosh (can be dangerous), Ginger root, Lemon balm, Mint, Motherwort, Parsley seed, Rue (some people are allergic to this), Safflower, Saffron, Sage, Senna (also highly laxative), Southernwood (can be dangerous), Strawberry leaves and fruit, Tansy (can be dangerous), Wintergreen leaves, Wood sorrel, Pennyroyal. Also: Black bean juice (because of possible iron content??). "Capping" over the navel. Take vitamin C (5 grams a day) for 6 days.—This dose may have side effects.)

Infertility. Workshop leaders: Johanna Periwasser, Assistant Professor of Obstetrics and Gynecology at a Boston hospital and Ellen Brevick, a social worker.

The causes of infertility (defined as one year's unprotected coitus without resulting pregnancy) break down as 40% male factor, 30-35% failure of ovulation, 20-30% tubal pathology, 5% cervical factor, and 10-20% unknown cause. Infertility problems require diagnostic steps for both the male and female partners in order to determine the cause(s). With proper evaluation and therapy approximately 50% of those who attend infertility clinics do become pregnant. The new chapter on childbearing problems in the revised edition of *Our Bodies Ourselves* covers most of the material presented.

Along with the scientific information, this workshop emphasized the lack of attention to emotional needs of infertile couples. Support groups (like RESOLVE—see "Resources"), can be especially valuable in this area.

Cancer. Workshop leaders: Val Donahue, a Boston gynecologist, and Carolyn Derbyshire, research analyst at a Boston hospital. Val Donahue discussed uterine and breast cancer. Carolyn Derbyshire focused on DES. Her paper on screening exams follows:

The Necessity Of Screening Exams For the Stillborn-Exposed Female

In 1938 diethylstilbestrol (DES) was synthesized as the first inexpensive, orally-effective synthetic estrogen introduced in medicine. It was most actively used in the United States in the 1940's and 50's but continued through the 60's and even 70's for the treatment of high-risk pregnancies. In 1971 the FDA contra-indicated its use for the therapy of high-risk pregnancies when an association between DES and a very rare cancer of the vagina in adolescent females was reported by Herbst and his colleagues at the Massachusetts General Hospital.

Who Is Considered To Have A High-Risk Pregnancy? It includes pregnant women with symptoms of bleeding, threatened miscarriage, history of prior miscarriage, diabetes, or hypertension.

Who Was Exposed To DES And What To Do? DES was

administered in the U.S. from 1940-1971). As of 1975, anyone currently between the ages of 4 and 25 years of age could have been exposed. A variety of measures can be employed to detect DES history: 1) The mother may be questioned. This is not sufficient evidence though, because not all mothers remember taking it. 2) The Ob-Gyn at the time of delivery may be contacted and asked to review the prenatal office record. 3) Hospital and pharmacy records may also be consulted; however experience has proven the Ob-Gyn and maternal histories to be the most effective approach.

When Should Exposed Females Have A Gynecological Screening Exam? What Should The Exam Include? A gynecological exam is a must for all exposed females who have menstruated for the first time. If menstruation has not begun by 14 years, an exam should be performed. For those who are younger and that have not menstruated, the exam is usually advised only if symptoms develop such as bleeding or persistent discharge. After the physician has been made aware of the DES exposure, the exam usually includes careful evaluation of the vagina and cervix, both by inspection and palpation. A Pap Smear will be taken. Iodine solution may be applied to the vagina and cervix and areas that appear abnormal will be biopsied. A colposcope, an instrument which provides a detailed view of the vaginal and cervical walls, may also be used for the examination. Such an exam can be done in the doctor's office and will take approximately 30 min.

What Abnormalities Can Be Found At The Screening Exam? Non-malignant changes may be frequently found. These are vaginal adenosis, a glandular tissue in the vagina, and cervical erosion, glandular tissue on the cervix. There are also other non-malignant changes that may be found frequently but it is important to emphasize that adenocarcinomas have been detected only very rarely. Most physicians will recommend that patients with non-malignant changes be followed 2-3 times a year until the natural history of these various changes is completely understood.

How Many Females Have Been Exposed To DES? What Is The Potential Risk Of Developing A Carcinoma? Estimates of the at-risk population have ranged from hundreds of thousands to several million. No one knows the risk of carcinoma developing in exposed females. In view of the fact that at present only slightly over 100 carcinomas definitely associated with DES have been reported, it appears that the risk of developing a carcinoma is extremely rare.

Women's Physiology. Workshop leader: Barbara Kass from the Boston Family Planning Project.

The workshop provided information related to the important medical aspects of the gynecologic examination with a review of the female reproductive system. The subject matter was chosen by the participants at the beginning of the workshop.

Barbara used pelvic and breast models to show the breast exam, the bimanual and rectal exam and an explanation of the routine tests to be performed annually: 1) three site pap smear-cervical scrape, endocervical canal, vaginal pool 2) two site gonorrhea culture-cervical sample, rectal sample 3) Serology for syphilis 4) hematocrit 5) urinalysis.

Discussion concerned the treatment of women by gynecologists with emphasis placed on the women's need and right to ask questions and the physician's responsibility to answer them.

The workshop also focused on female sexuality with a history of the Masters and Johnson research, and a review of the four sexual response stages of the female. Throughout the workshop participants enthusiastically asked questions and shared experiences.

Herbal Medicine and Folk Medicine. Workshop leaders: Dian Dornin Buchman, author of *The Complete Herbal Guide to Natural Health and Beauty*, and Sister Guru Priya, a physician who lives at Satchidananda Ashram in Pomfret, Connecticut.

Presented were samples of herbs, information on their preparation (decoctions, infusions, and tinctures) and on when and how to use them. At the workshop on Folk Medicine a woman from the Ashram demonstrated specific yoga postures beneficial to women's health. Both workshops were primarily an exchange of

information among Ms. Buchman, Sister Guru Priya and the audience about specific herbs and their application to problems of health and healing. The following information was handed out:

Herbal Remedies for Vaginitis

By Sharon A. Dornoin
Leshian Health Center, Seattle

Many women are turning to herbal remedies for their vaginitis—this is a good way to get into herbs as a way of life. Herbs are not like "regular" medicines. Roughly, "regular" medicines tend to kill off the "bug," and herbs tend to restore the body to its normal environment, and promote healing. Don't be deceived into thinking herbs are harmless; many herbs are potent and you should know what you're doing, by reading herb books or talking to more experienced people, before you experiment much. The remedies listed here are easy to use if you have no previous herb experience. The list is not extensive but is a good starting place. If one doesn't work, try another; if one has worked in the past, try it again. Usually if a remedy is working, it will work within a week. If not, consider a different herb or a different approach.

*Before you treat yourself, be sure you don't have VD, or an infection that involves your uterus, tubes, and ovaries (if you have fever, or pain in your lower abdomen, check this out before using anything.) Use these after you are sure you really have a vaginal infection and nothing more serious than that.

*You can do a lot to prevent vaginitis: wear cotton underpants; wipe front to back after a bowel movement; don't share washcloths or towels; avoid chemicals (barsh soaps, perfumes, commercial douches, sprays, etc.); avoid sugar and sweets and refined foods. Be sure you get enough vitamins B, C, A, and E; eat unrefined nutritious food, and get enough sleep. If you're run down and/or in poor health it's easy to get vaginitis; it's harder if you are healthy.

*Douching: Don't douche except for curative reasons. When you douche for vaginitis remember—it is possible to force air or fluid into the uterus and abdominal cavity. If these instructions are not clear enough, find a paramedic, nurse or doctor who can clarify them for you.

- use lukewarm water to your comfort.
- douche in a tub or on a toilet, but never have the bag more than 2 feet above your hips, or never squeeze a bulb type bag too firmly.
- wait until the air is out of the tubing and the solution starts running through before putting the nozzle into your vagina.
- if you are pregnant, don't douche. If you ever experience abdominal pain, possibly with fever, after douching, see a doctor or hospital that same day. This doesn't happen often, but it is possible.

Alternatives to douching: Some of these remedies can be poured into a few inches of bathtubwater, then you can sit with your knees apart, open your vagina slightly by inserting one or two fingers and pulling down slightly to let the water run in. You can also use your finger to try to wash out discharge and bathe your vagina with the herbal bath water. Don't rub too hard—you can irritate yourself.

With, or instead of this, you can soak a tampon (out of the tube) in the herbal solution, then insert it into the vagina overnight or for several hours. This technique is tricky. If you have a diaphragm, put the wet tampon in the diaphragm, fold it together and insert it as usual. Then, slip the diaphragm out while leaving the tampon in place. Or if you have a plastic speculum (available at women's Self-Help centers) insert the speculum, open it enough to push in the tampon, then hold the tampon in place with one hand or finger while removing the speculum with the other. Use any other technique you can think of that is not dangerous. This method may or may not drip, depending on your anatomy and how wet the tampon was, so you should use a pad until you're sure. You can also hold an herb-soaked pad to the genital area for 5 minutes to several hours to relieve external itching and soreness.

Pre-packaged herbs are more expensive than bulk. Most cost from 15 cents to \$1.00 per ounce. Golden Seal is usually more because it is concentrated. Never use aluminum straws to

prepare herbs. Four cups equal 1 quart. $\frac{1}{2}$ to 1 ounce is usually enough for a vaginal infection.

For beginning yeast infection: yogurt douche—add 2-3 tbsp. plain yogurt to 1 qt. warm water. Douche daily for up to a week.

Yeast or non-specific: garlic—each day for 3 days insert a clove of garlic into the vagina (change each day). You may want to wrap it in gauze to insure easy removal. After the 3rd day, use a vinegar douche once—2 tsp. vinegar to 1 qt. warm water.

Yeast or non-specific: bayberry bark—bring 1 qt. water to a boil. Add 2-3 tbsp. bayberry bark, and boil gently for 20 mins. Strain, cool, add more water to make a quart again if necessary, and douche daily for a week.

Yeast or trichomonas: goldenseal and myrrh douche—boil 3 cups water; add 1 tsp. each goldenseal and myrrh, simmer 20 min. Then either let sit and pour the liquid off the top when it settles or strain through a cloth. Add water to make quart total, and douche daily for a week.

Trichomonas: Chickweed douche—boil 1 qt. water, remove from heat, add 3 tbsp. chickweed. Cover, let sit 5-10 mins., strain, and douche daily for a week. If you have trich, any sexual partners you have need to be treated too. For women, just use the same thing. For men, see a naturopathic doctor, use the usual medicine (flagyl pills by prescription), or hunt down some other cure.

Non-specific (beginning): Alternate vinegar and salt water douches for a week. That is, vinegar douche one day, salt water douche the next day, etc. Vinegar: 2 tsp. to 1 qt. water. Salt water: 1 tbsp. per 1 qt. water. Use a yogurt douche on the last day—2-3 tbsp. plain yogurt to one qt. water.

Any vaginitis: goldenseal—bring 2 cups water to a boil. Add 1 tsp. goldenseal powder, simmer 20-30 min. Let cool, then either pour the liquid off the top or strain it through a cloth. Add water to make a qt. total; douche daily for a week.

Any vaginitis: calendula (marigold)—bring three cups water to a boil. Remove from heat and add a handful (or about 4 tsp.) calendula. Cover and let sit 5-10 min. Strain, add water to make a qt. total, and let cool. Douche daily for a week.

Primary Care or Home. Several workshops led by: Cathy Cranford RN, Mary Howell MD, and Margaret Craig RN, and Barbara Blakely RN.

Cathy Cranford's workshop focused on emergency first aid, accidents, childhood diseases and poisoning.

There was a strong interest in accidental poisoning and lead poisoning. Cathy brought in a sample of lpicar spray which is most often used in cases of poisoning. Lead poisoning was discussed in terms of legislation, prevention, and the lead poisoning centers located in Boston.

Regarding emergency first aid, the basic "how to" information about cuts and abrasions, fractures and burns were reviewed. There was discussion on what to do at home and what to do if you're on a camping trip with no water and equipment.

VD. Workshop leaders: Barbara Carlson and Estelle McDougall from the Mass. Department of Public Health.

This workshop pointed out that "correct" terminology is no longer "venereal disease" but is now "sexually transmissible diseases."

Estelle presented information on the epidemiology and progression of syphilis and gonorrhea and the other less common or less serious of the sexually transmissible diseases. There were slides of the symptoms. Barbara Carlson gave an in-depth discussion of the problems of isolating gonorrhea in women.

Abortion. Workshop leader: Marilyn Spivak (FWHC, LA, CA).

There was a general description of the procedure including pregnancy testing, instruments used in abortions, a videotape of an abortion from the Feminist Women's Health Center in LA, and information on clinics in Boston. (See also, The Abortion Procedure, in "Resources" section.)

There were women at the workshop who came for this basic information. Other women, however, were already involved in clinics doing abortions and wanted to exchange information on their services and receive new information on all aspects of running clinics.

Massage. Two workshops; one led by Jewel's Stamp (of the NAMA Collective) and Bobbi Lev (of Ananda), and the other led by Debbie Rose and Kate Davies (of Ananda).

Both workshops featured exercises to prepare for massage, and massage demonstrations. Massage is nurturance. Through massage we soothe our friends, lovers and children, and get in touch with our power of healing as women. Massage does not demand the selfless nurturance which has subjugated women in the past, but instead creates a channel for healing energy so that both the massaged and the masseuse emerge from the experience renewed and refreshed. We accomplish this by learning to center our energy through breathing and awareness.

SELF HELP

by Elizabeth Sommers
Women's Community Health Center
Cambridge, MA

Self-help is both a philosophy and a practice through which we become active creators of our own destinies. The political ramifications of understanding and taking control of our bodies are apparent both on a personal and on a global level. For ourselves, we can find a new independence from the traditional doctor-male/patient-female relationship, which has both stifled as intellectually and debilitated us physically. Globally, we see how imperialism has affected all women in both developed and developing countries, making us guinea pigs in population control and drug experimentation.

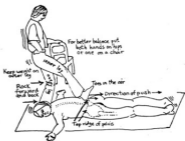
Sharing knowledge and skills is a basic tenet of the self-help movement. Our presentations at the 1975 Conference on Women and Health were aimed at women of all ages and backgrounds, and attempted to de-mystify aspects of our health care. Gynecology has traditionally placed us in an inferior role in a power structure determined almost completely by a white male elite representing an even larger fraction of a capitalist male society. Learning basic facts about ourselves and our bodies, and unlearning the lies of years of sexist medical practices, is what self-help is about. Medicine today, based on crisis-orientation and pathology, has little to do with our daily lives as healthy women. We seek to change both the structure and the content of medical care, always trying to be attentive to the needs of women as whole beings.

During the four days of the conference we met almost 300 women from all over the country. Many of these women will return to their homes and, in the finest traditions of our foremothers, spread the message of self-help through their jobs and in their social contacts. Response to our presentation was always heartening and exciting. For some women, self-help meant looking at their cervixes for the first time; for others it signified acquiring a new degree of control over their reproductive lives. Every woman, however, left with a new sense of optimism about herself and her life. We are all sane and healthy, and each of us can be a healer for ourselves and our sisters.

Concluding Comment. Some or all of the above workshops form a necessary base of information for a women's health conference. We also found that the network of connections we built up in locating speakers for our workshops was a valuable outgrowth of the planning process. If we were to go on in the vein of our workshops, we would plan community health days on a smaller and more community-conscious scale to impart some of the same information to women who never got to our conference.

MENSTRUAL MASSAGE

— FOR TWO PEOPLE
— TO RELIEVE CRAMPS



WOMAN WITH THE CRAMPS

*Lie flat on your stomach, with or without clothes.

- Use a blanket under you for extra comfort.
- Have your arms straight out or slightly bent at the elbows.
- Point your toes inward if possible.

*Tell the other person what feels good and what doesn't.

- It should feel good.

PERSON GIVING THE MASSAGE

Basic Movement:

*Remove your shoes.

*Stand, placing your outer leg next to the head and above the shoulder of the person on the floor.

*Put the heel of your inner foot against the edge of the top ridge of the pelvis (same side you are standing on). See diagram.

*"Hook" your heel as much under the bone as you can.

- If you are not sure where this pelvic ridge is, feel for it first with your fingers. It may be higher up on the back than you think.

*Keep both legs in slightly bent positions.

*Gently push away from you, toward the feet, at regular intervals of once or twice a second.

- Rock your whole body together by bending only at the knee and ankle of the outer leg (one you are standing on).
- Move forward and back. Avoid a circular motion.
- When you are pushing firmly enough the whole body of the woman getting the massage will rock too.
- Try not to push towards the floor with the inner foot. Keep the toes pointing upward to prevent this.
- Keep your heel in contact with the pelvic bone so the woman getting the massage won't feel bruised.

*Increase the frequency and length of the push as long as the person with the cramps says it is comfortable.

- You will probably need to work more vigorously than you first imagined.

When you feel comfortable with the basic movement:

*Move the location of your heel from side to side to push at different spots along the ridge of the pelvis.

- Do this all along the side you are standing near.
- Avoid the spine.

*Do this for a few minutes.

To finish the massage:

*Move to the other side of her body.

*Change feet. Inner and outer legs switch now.

*Repeat the basic movement, etc.

*Change sides as often as you want. Continue with the massage until the other woman's cramps diminish or go away.

WOMEN AND MENTAL HEALTH

Unfortunately, this is one topic for which a report was not submitted. The following material about therapy and Jean Baker Miller's presentation (elsewhere in the *Proceedings*) do not cover by any means the scope of issues discussed in women and mental health workshops.

Though many of us often are able to get the therapeutic help we need from friends and/or various support groups, there are certain problems for which we may want to see a therapist. Because therapy usually costs money, it is not a real option for most women. Feminist therapists have tried to deal with this problem by charging fees on a sliding scale and by working towards the recognition of therapy as a service that should, like any other health care service, be available to all of us. Meantime, those of us who can and do choose therapy need to be aware of our rights. Following are excerpts from an informative handout used in several of the mental health workshops:

Your Rights As a Woman in Therapy

from the Women's Liberation Center and the Therapy Rights Committee, 215 Park St., New Haven, CT.

also printed by the Advocate Press, 441 Chapel St., New Haven, CT, as a 14-page booklet including an appendix of agencies in New Haven.

Your Basic Rights as a Consumer of Therapy

Every woman can expect the following rights:

The right to have a therapist she trusts and with whom she feels comfortable. This includes the right to interview and choose a therapist—i.e., to "shop around" first.

Complete confidentiality in the therapeutic relationship.

Reasonable fees. This includes taking account of her special circumstances as a woman.

To be treated with respect and not be oppressed by a therapist with sexist or authoritarian attitudes.

The right not to be a patient. This includes the right to reject or withdraw from a particular kind of treatment, a particular therapist, or any treatment at all.

Freedom of sexual expression without being labeled "sick." This includes sexual partners of either sex.

Finding a Therapist

Be sure therapy is what you want.

Inform yourself about the different kinds of therapists, agencies and therapies available.

Get the names of recommended therapists. A women's center in your area may have such a list. If the therapist has no free time, ask for other names.

If you call a private therapist . . .

Call the therapist. Ask for an "initial interview" and find out if the therapist has free time to see you on a regular basis. You will probably have to pay for this initial visit.

If you call an agency . . .

You may have to go through an "intake interview" before you see a therapist. An intake interview is given so the agency can assess how they can help you. You can refuse to participate in any procedures you find objectionable. When talking to any therapist in an agency, ask if you are going to see the same person on an ongoing basis and for how long. Save your interview of the therapist until you have established with whom you are going to work.

Shop around . . .

Interview as many therapists as you want and can afford until you find one you think you can work with. If necessary, ask for a second interview.

Be a Careful Consumer

When starting therapy, you can keep your independence of judgment and freedom of choice. You can expect the same rights from a psychotherapist as you can when you consult a dentist for a toothache or an accountant for a tax problem. Psychotherapy is a

place to discuss your emotional problems but the therapist should not be the proper judge of your values. The therapist has no more right to determine your politics than the dentist has to give you legal advice.

Many people have been "oversold" on the authority of psychiatry; you should not expect magical results. Therapists can help clarify your problems and help you cope with them better, but they cannot solve the major difficulties of existence for you. No amount of professional training can turn a therapist into an expert on how you should live your life. Studies have shown that many people do not benefit from therapy and some may be harmed by it.

Do not be too impressed by a psychiatrist's medical degree. The matters you discuss are basically personal and emotional, not medical. Just because physicians can prescribe pills does not mean they can understand your problems better than others. The kind of person a therapist is may be much more important than her or his professional credentials.

Clinical treatment is not necessarily inferior to private treatment although it does cost less. Many of the same psychologists, social workers and psychiatrists who work part-time in clinics for \$10 a session charge \$30 in their part-time private practice. However, you should be aware that clinics are often staffed by people in training. In a clinic you may be switched from one to another therapist after a period of time.

Because most "patients" are women and most therapists are men, therapy perpetuates the idea of the "helpless female and competent male." In fact, many of the ideas and practices of standard psychotherapy are opposed to the goals of Women's Liberation. Some therapists see our difficulties as the result of individual "illness" and do not recognize or refuse to acknowledge that many of our problems stem from the outside world and should be dealt with politically. Many therapists have been trained in the ideas of Freud, who believed that women are emotionally and intellectually inferior to men and that women should learn to adjust to submissive roles. As a result, some therapists may believe that women are "maladjusted" if they are not satisfied with staying home and taking care of their children full time. Not all therapists have such rigid views, but don't be surprised if you encounter these ideas.

Being a careful consumer means knowing the values as well as the limitations of therapy. The following are some of the potentials which we see in a good therapy relationship. First, it is an opportunity to discuss problems and alternatives. Also, it is a chance to relate to someone who is fairly objective, a sounding board for your feelings, and who can help you clarify your situation. Further, it may be a chance to talk about things you don't feel comfortable discussing with anyone else. Finally, there are women who feel that therapy has helped them to change their self-concept from a negative to a positive one, or who feel that through therapy they have been able to do more with their lives.

Interviewing a Therapist

During initial sessions, a therapist will usually interview you about your problems, feelings and history. We recommend that you interview the therapist about matters relevant to your therapy. You may not feel comfortable asking all these questions initially, but as soon as possible you should find out where your therapist is at. This will help you determine whether she or he is the therapist for you. It will also help to set a tone of equality in the relationship.

We offer the following questions only as a guide. You may not want to use all of our suggestions, and you may have questions of your own that are more relevant to you.

It should be noted that a therapist may reply to a question with "Why do you want to know?" This is a legitimate response to some questions and as such deserves an answer. But it also can be used to avoid your questions. Be careful not to fall into that trap. Hopefully, a therapist will not respond with pat answers but with honest dialogue which can be continued throughout the course of your therapy.

What are the therapist's views on Women's Liberation and ideas about the social and economic causes of women's "problems"? How has it affected her or him personally?

Where did the therapist's ideas come from? What is the