

therapist's experience and theoretical framework? Has she or he been in therapy?

What type of therapy does the therapist recommend—long or short term, group or individual therapy or both? If individual, how many times a week would you meet?

Will the therapist in interaction with you be active, passive, or somewhere in between? What type of interaction do you prefer?

Will the therapist admit mistakes and accept criticism? Reactions to this question can be revealing.

What are the therapist's views of questions of life-style that are important to you, such as staying single, living with a man, lesbianism, communal living, living alone, marriage, children, etc.?

Will the therapist be available at times other than scheduled hours, i.e., can she or he be called at home? If necessary, will she or he arrange for you to see another therapist during her or his vacation? You have the right to know in advance when your therapist will be away on vacation.

Will the therapist allow you time to make up your mind about starting therapy with him or her?

Evaluating an Interview

Your initial interview is a preview of what working with this particular therapist will be like. Think it over carefully. Determine what you feel. We recommend that you trust your feelings. Remember, if your reaction is basically negative, now is the time to find a different therapist—before you have made a large personal and financial investment. (But remember, you can change later too.)

To analyze the interview, you may find the following questions helpful:

Was I satisfied with the therapist's answers to my questions? Was she or he direct or evasive?

Did the therapist treat me as a human being or as a sick person?

How much of a person was the therapist, as compared to a blank wall?

How comfortable was the office environment?

Do I feel the type of help the therapist recommends is what I want or need?

Learn About Your Basic Rights

Confidentiality

With whom will the therapist discuss your case? This is especially appropriate to ask in any agency or institutional setting.

No therapist has the right to reveal information about you to any other person or institution. This means that she or he may not use your name or discuss your case with anyone, including other professionals, friends or relatives without your written permission. The only exceptions are patients committed to mental hospitals and agencies where staff members may have to confer with each other about you. Your communication with a psychiatrist or other therapists under his supervision is protected by Connecticut state law. Other therapists are bound to confidentiality by professional ethics. It is unwise to sign a form giving blanket permission for the use of your records; be sure you know what information is going to whom.

A special problem may arise in group therapy where you will be dealing with a number of other patients who are not so bound by law or professional standards. If you are worried that members of the therapy group may talk about you to others, you should discuss it with them.

Mental Hospital Commitment

Does the therapist or agency have the power of commitment to a mental institution?

You should be aware that a psychiatrist has the power to commit you to a mental institution. This is rare, but it can happen. The risk is greatest if the psychiatrist is convinced that you are seriously considering suicide, that you will injure others, or that your thinking is so confused that you cannot take care of yourself. This also happens frequently to persons who go to hospital emergency rooms suffering from the disease of alcoholism. You may ask at any time if a psychiatrist is considering mental hospital commitment, and if you are against this, you have the right to

leave any time before commitment papers are signed and the right to consult a lawyer. You have a right to be examined by a psychiatrist of your own choosing and if this psychiatrist says you need not be hospitalized, they cannot commit you.

Fees

How can you agree upon a reasonable fee with the therapist? Before or during the initial interview, settle on a fee. There is no sense going into your problems if you cannot afford the fee. Some agencies and therapists adjust their fees, so be sure to explain your situation fully.

Inability to pay fees is not a sign that you won't take therapy seriously. Women generally have less money than men; we are paid less than men. Many married women have access to virtually no funds—their ability to pay has nothing to do with their husband's income. A woman coming out of a marriage faces legal fees and many expenses formerly absorbed by the marriage. Women must deal with daycare expenses if they are to do anything without their children—this includes work, school and doctors.

Therapists and agencies should set their fees taking into consideration the special expenses of women, who are changing their family structure, who are students, who are working or who have other expenses which drain their ability to pay for therapy. A flat rate charged to everyone or a sliding scale based only on gross income is not an equitable arrangement. We suggest that therapists and agencies be responsible for trying to change those conditions which interfere with fee setting according to these principles.

What are the therapist's/Agency's policies toward fee payment and scheduling. Most therapists like to be paid by a certain date of the following month. Ask if they charge for cancelled appointments, etc.

Medication

Does the therapist give medication? What are her or his attitudes about it? You have the right to full information on any medication or treatment recommended by a doctor. Before deciding to accept medication or treatment, you may wish to inquire about all side effects. Individuals vary widely in their sensitivity to tranquilizers. If you are dissatisfied with the results of medication, discuss them with the doctor. If you are not given an adequate explanation of a change in the prescription, you have the right to either not take the medication or consult another physician.

Handling grievances during therapy

Some of your complaints and dissatisfactions may be a form of resistance to facing painful things about yourself. At the same time they may be legitimate grievances. Take your dissatisfactions seriously and try to resolve grievances with your therapist.

If you are dissatisfied, think about what it is you don't like. Are there specific rights that are being violated or is there a more basic problem? Is it a result of sexist attitudes on the part of the therapist? Is it a personality clash? Maybe this isn't the therapist for you. Maybe you don't want therapy after all.

When you feel sure your rights are being ignored, ask for a change. Be specific as to what you disagree with, and be ready to explain it over again. Your therapist should hear you out, accept how you feel, and try to understand your viewpoint. The therapist should be able to work toward changes that insure you your rights.

Consider, but do not necessarily accept every argument your therapist may use to answer your criticism. Some points may be correct for your case. At other times, they may be used defensively by the therapist to keep authority or to avoid dealing with your grievance. Common arguments against discussing the particulars of a grievance are:

It is less important than discussing your problems or how you feel when you are angry.

You are avoiding looking at yourself and the changes you must make.

You are "resisting" by focusing on the therapist [instead of yourself].

As the expert, the therapist is in the best position to decide how to give therapy, set fees, handle clients, etc.

If you have trouble discussing your grievances or making changes, you may wish to talk to another therapist or a supervisor, if it is in an agency. We suggest that agencies make arrangements for clients' problems to be handled by a service representative, advocate, or specific supervisor. If you remain dissatisfied and feel you have tried everything, you may have to terminate with that therapist and find another.

MATERNITY CARE

Introduction

Four months prior to the Conference all of the groups in the Boston area working on childbirth and maternity care issues were contacted and invited to help plan Conference workshops. At that time there were about ten such groups* and all participated. The planning group ultimately decided that there would be two basic panel discussions on the two major Conference days, one on pregnancy, preparation, and decisions about the birth experience, and the other on the actual birth and postpartum experiences. Groups with special interests held separate workshops. A total of 18 workshops were held, with one or two repeats.

The two panel discussions described the range of choices and resources directly available to pregnant women, how the actual experience might be more satisfying, and what could enhance the coping period afterwards. A brief history of the development of the types of childbirth groups was also presented.

The first panel presented a variety of ways for parents to plan and prepare for childbirth, including ongoing discussion groups for women, couple-oriented childbirth preparation classes, and informal clinic classes.

Homebirth and lay midwifery were also included. The second panel covered both home and hospital birth in more detail, as well as both breastfeeding and postpartum support. Special discussion of the rights of hospitalized mothers and babies was included here.

Special workshops were held on Caesarian-section births, childbirth for working-class women, lay-midwifery, homebirth, childbirth drugs, and the politics of maternity care. For most women, new information came out of the discussions on midwifery, home birth, and postpartum. Five years ago there were a few isolated programs; today, there is a whole movement towards alternatives to hospital birth and a growing network of postpartum support programs, which have been added to the now-established childbirth preparation programs.

In addition to the workshops coordinated by the Maternity Care Committee, related workshops were given on infertility, parenting, and children in hospitals (coordinated by other committees).

*Boston Association for Childbirth Education, Birth Day, Homebirth, Boston Women's Health Book Collective, Lamaze, La Leche League, COPE (Coping with the Overall Pregnancy Experience), C-See, and Children in Hospitals.

Issues Surrounding Contemporary Birth Practices

Introduction

Global, overview issues and considerations which to some extent affect medical practice broadly, and form the context onto which the specific childbirth issues can be seen.

- The individualizing rather than the routinizing of health care.
- Limitations on the physician due to his/her training and belief in the prevailing medical orientation (generally, and specifically in Ob.). Contrast with the growing development of experimental, midwifery orientation.
- The persistent contrast between private care and clinic care in all dimensions: attitude, management and medical technology.
- History of experimentation in obstetrical practice (also attendant pediatric and anesthesiological practices) which have produced, may continue to produce iatrogenic illnesses/effects.

Major Issues

Sequenced to follow the development of pregnancy, labor, birth and the postpartum adjustment.

1. Education, preparation and training of mother and her family for childbirth and parenthood: Who does it, when to do it, why do it and what is it? The various methods/approaches and the movements of the last four and a half decades.
2. Pregnancy: Sex drive and sexual activity, nutrition, psychological changes. Toxemia of pregnancy as a disease of malnutrition. Preparation for childbirth, involvement of fathers, development of a support system for the mother for classes, labor & delivery, postpartum and beyond.
3. Labor: At home and in hospital. Physical and physiologic positioning. Rupturing of membranes for induction or to speed labor or for purposes of monitoring. Medications: varieties and risks/benefits. Anesthetics and their related procedures (specific regional anesthesia procedures, e.g., IV, Saline/glucose, Oxytocin, rupture of membranes, monitoring). Fetal monitoring, knowns and unknowns—psychological effects, legal fallout, procedure on infant, statistical data. Episiotomy, enema, prep, minor issues.
4. Delivery: Positioning (back/backrest, feet/straps), relation to outcome and intervention. Emotional support as exclusive role: fathers, or other mates, staff. Spinal anesthetics, rationale, uses and abuses. Timing of cord-cutting and placental transfusion controversy. Release of placenta. Immediate mother-infant contact: Nursing, imprinting, temperature studies/issues. Physiologic benefits to mother, infant.
5. Postpartum: In hospital, at home and in community. Mother-infant interaction and outcome. Couple dynamics/interaction and roles, special father needs. Sleep and nutrition, esp. for mother, also infant, father. Sexual activity. Mother's adjustment, minor/major depressions and prevention (Who has medical responsibility for mother's non-physical wellbeing? Where does psychological support, nurturance for mother come from?). Breastfeeding. Importance of peer support.
6. Home birth as a growing alternative: Motivations, characteristics of those who seek, do. Qualifications, attitudes of attending personnel. Midwifery: Lay vs. Professional. Technological evaluation, intervention of hospital birth. Risks of childbirth in hospital vs. home.

Comparisons Between the Prepared Childbirth Movement and the Home Birth Movement

By Norma Swenson

In the medical world home birth is a controversy because of the complex medical, ethical, and legal questions it raises for practicing physicians and, to a lesser extent, for hospitals. In the wider society, however, home birth can be looked at as a movement which can be compared with other movements for social change. I think there are a number of parallels between the home birth movement and the prepared childbirth movement of the fifties and sixties for example, and I would like to explore some of them.

Most medical professionals with whom I've discussed the home birth movement were violently opposed to it and do not see it as a trend at all but rather as the isolated foolishness of a very few individuals. Many physicians apparently believe that the relative absence of complications and unsuccessful attempts appearing in emergency rooms afterwards is evidence of the small numbers and the "passing fad" nature of the phenomenon.

It was this response of the physicians that stimulated me to begin making some systematic comparisons between the prepared childbirth movement and the home birth movement. Having lived through the prepared childbirth movement, I can remember vividly that when childbirth classes were first started there was strong opposition to them, too. Women who asked for this type of experience were also seen as foolish or peculiar or both. The innovator, whether patient or physician, was penalized, harassed,

THE PREGNANT PATIENTS' BILL OF RIGHTS

American patients are becoming increasingly aware that well-intentioned health professionals do not always have accurate data to support common American obstetrical practices and that many of these practices are not primarily for their benefit. They are part of medical and hospital traditions. In their own lives, they are aware of patients' medical decisions which have been made for them by health professionals without their consent. They are also aware of the distress that health professionals caused them, sometimes unconsciously, and many of them are particularly dissatisfied for the fetus and even for the mother. A growing body of research makes it clear that their own expert or traditional American hospital care during labor and delivery must now be questioned as to its possible effects on the future well-being of both the obstetric patient and her unborn child.

One reason 14 children born in the United States today will eventually be diagnosed as retarded is that 75% of them are born to mothers who have had a cesarean section. Another 10% of children have been found to have some form of mental retardation in a hospital disability research study of 1974. Mothers. Such statistics are not confined to the least socioeconomic group but are areas of regression of American society.

New concepts are being tested by childbearing women because we now know the degree of average depression, fetal progression, or infection by escape the mother, or newborn infant can interfere before the child is born. Health professionals are aware of the effects of cesarean section on the mother and the newborn child. In the U.S. Food and Drug Administration use the fact that a drug is prohibited for a pregnant woman if a guarantee that a drug or medication is safe for the mother or her unborn child. In fact, the American Academy of Pediatrics' Committee on Drugs has recently stated that there is no drug, whether prescription or over the counter remedy, which has been proven safe for the unborn child.

The Pregnant Patient has the right to participate in decisions involving her well-being and that of her unborn child. She has the right to be informed of the risks of any procedure or drug which she is to use or to which she is subjected in the American Hospital Association's "Patient's Bill of Rights," which has also been adopted by the New York City Department of Health as the Pregnant Patient, because the requirements (TWO) patients under their care, should be recognized as having the additional rights listed below.

- The Pregnant Patient has the right, prior to the administration of any drug or procedure, to be informed by the health professional caring for her (or any personal doctor or delivery staff), of risks to herself or her unborn or newborn infant which may result from the use of a drug or procedure prescribed for her during pregnancy, labor, birth or lactation.
- The Pregnant Patient has the right, prior to the proposed therapy, to be informed, not only of the benefits, risks and hazards of the proposed therapy, but also of known obstetrical therapies such as available childbirth education classes which could help to prepare the Pregnant Patient physically and mentally to cope with the demands or stress of pregnancy and the experience of childbirth, thereby reducing or eliminating her need for drugs and obstetric intervention. She should be offered such information early in her pregnancy in order that she may make a reasoned decision.
- The Pregnant Patient has the right, prior to the administration of any drug, to be informed by the health professional who is prescribing or administering the drug to her that any drug which she receives during pregnancy, labor and birth, or sometime thereafter, when the drug is taken or administered, may adversely affect her unborn baby, directly or indirectly, and that there is no drug or chemical which has been proven safe for the unborn child.
- The Pregnant Patient has the right if Coe's written is not qualified, to be informed prior to the administration of any drug and procedure prior to her hospitalization, of the risks of using her and, in turn, her baby's intake of nutritional, pharmaceutical and health care.
- The Pregnant Patient has the right, prior to the administration of a drug or procedure, to be informed of the areas of controversy if there is NO properly conducted follow-up research which has established the safety of the drug or procedure as well as to have and/or address all facts on the physiological, mental and neurological development of the child exposed, via the mother, to the drug or procedure during pregnancy, labor, birth or lactation - this would apply to virtually all drugs and the vast majority of obstetric procedures.

The following was a handout at one of the Politics of Maternity Care Workshops

- The Pregnant Patient has the right, prior to the administration of any drug, to be informed of the health status and general course of the drug or other that she may affect the health and mental of any past adverse reaction to the drug.
- The Pregnant Patient has the right to abstain, for herself, without pressure from her attendant whether she will accept the risks inherent in the proposed therapy or taking a drug or procedure.
- The Pregnant Patient has the right to know the name and qualifications of the individual administering a medication or procedure to her during labor or birth.
- The Pregnant Patient has the right to be informed, prior to the administration of any procedure, whether that procedure is being administered to her for her or her baby, of known medical risks, side-effects or an adverse procedure, that administration, including prognosis or treatment.
- The Pregnant Patient has the right to be accompanied during the course of labor and birth by someone she trusts for, and to whom she looks for emotional comfort and encouragement.
- The Pregnant Patient has the right after appropriate medical consultation to choose a position for labor and for birth which is best suited to her baby, and to travel.
- The Obstetric Patient has the right to have her baby, cared for at her behest if her baby is normal, and to hold her baby according to her baby's wishes unless that according to the hospital regulations.
- The Obstetric Patient has the right to be informed in writing of the name of the person who actually delivered her baby, and the professional qualifications of that person. This information should also be on the birth certificate.
- The Obstetric Patient has the right to be informed if there is any known or indicated aspect of her or her baby's care or condition which may cause her or her baby harm (difficultly or problems).
- The Obstetric Patient has the right to have her and her baby's hospital medical records complete, accurate and legible and to have their records, including Nurses' Notes, obtained by the hospital until the child reaches at least the age of majority, or, alternatively, to have the records offered to her before they are destroyed.
- The Obstetric Patient, both during and after her hospital stay, has the right to have access to her complete hospital medical records, including Nurses' Notes, and to receive a copy upon payment of a reasonable fee and without incurring the expense of traveling in a stony.

It is the obstetric patient and her baby, not the health professional, who must contain any stresses or strains resulting from the use of a drug or obstetric procedure. The observation of the rights listed above will not only permit the obstetric patient to participate in the decisions involving her and her baby's health care, but will help to protect the health professional and the hospital against litigation arising from over- or mis-understanding on the part of the mother.

Birth order: With each plus to the principle and handling
For a complimentary copy and a complete list of available materials to the
Committee on Patient's Rights at Box 10000, New York, New York 10010

belittled, or denied. It was also presumed that this was temporary craze which large numbers of normal people would never prefer to the finest level of care then available. Myths grew up about natural childbirth which persist to this day. Myths have already been created about home birth as well.

Some Myths Surrounding the Home Birth Controversy

- *Home birth enthusiasts believe that all births should take place at home.
- *All home births are unsafe and should be outlawed.
- *Emergencies which occur during home births would be prevented if the births took place in hospitals.
- *All hospital births minimize risks and provide the best care possible; emergencies that occur there could not have been prevented.
- *Care given by other than a physician or a nurse-midwife is incompetent care.

First, it seems helpful to take a sociobiological view, to look at the characteristics of those who began each of these movements alongside those precipitating factors in the culture and the society of the times that can be identified. In comparing the movements, the motivations of those who sought changes are looked at together, as are the common techniques and byproducts of their efforts. Also compared are the characteristic resistances of those who opposed each of these efforts, and the tactics used by each side in the conflict to achieve its goals. Finally, some features which differentiate the two will be discussed, followed by a brief look at what may happen in the future.

The Originators

Each movement began with the individual responses of a number of women, each of whom privately concluded that the existing system was unacceptable and found other women of like mind. The very first women were either socially elite or were already social critics concerned in other ways about the quality of life. In Boston, for example, the Boston Association for Childbirth Education (RACE) was founded in 1953 by a group of physicians' wives and enjoyed the endorsement of the Commissioner of Public Health. In other cities during the fifties many other founders had deep religious or moral convictions about the nature or significance of childbirth and its place as an event in family life. The early home birth couples and groups have already been described.

Motivations

Each movement has been in some sense created out of the failures of the earlier efforts. In the case of prepared childbirth, the early private efforts of individual women were very often frustrating and even disastrous experiences, which led many women and many doctors to conclude that "natural childbirth" was a myth. Others recognized, however, that the entire concept was alien to the training and belief systems of physicians and hospitals, and that success was only possible with preparation, training, and support on a systematic basis. In the case of home birth, the need for a broader base of support and an exchange of information to improve the individual experience became evident almost immediately.

Both groups have long been aware that planning of maternity care services in the United States, both prenatal care in all its forms and hospital and postpartum services, has been one with virtually no input from the consumers of these services. Even carefully organized long-term protests have in many cases yielded nothing. The home birth groups appear to be more realistic in this respect than the prepared childbirth reformers—both more sophisticated about the limited value of making requests from providers in authority and more insistent that they are entitled to have their needs met on their own terms. Forming organizations and movements is thus the only mechanism available to achieve any input whatever.

The Organizers

Following the original innovators have come the organized groups composed almost exclusively of college-educated, middle-class volunteers who are economically able to patronize the existing "best" private care system but are highly critical of it. These couples are almost always readers, well informed on a wide variety of subjects and often confident of their ability to demystify and understand complex material in both lay and scientific literature.

Reproductive Philosophy

Each group could be described as reflective of the "postcontraceptive age" at a different point in time. The prepared childbirth couples were planning either to have only a few children or (often for religious reasons) to have many children. In either case, the quality of each experience then took on a heightened importance, leading to a more critical examination of the routine experience then available and a desire to individualize, personalize, and humanize rather than routinize their own births. The home birth couples, many of whom are planning no more than one birth in their lifetimes, feel an even greater need for a unique, emotionally rich experience. For them it is an event which has long been postponed and may never be repeated.

Characteristics

For the most part, those interested in these movements are family-oriented people who spend large amounts of time with one another and include a strong focus on the importance of the father in the life of the family, the dignity and autonomy of the mother, and a sense of the infant as a separate person, even during pregnancy. Their sense of entitlement is strong.

Both groups appear to be psychologically oriented—concerned for the emotional impact of experiences on psychological development and cognizant of the value of preparation for important life events. They appear to believe in the value of confronting realities as they happen rather than avoiding or postponing them. They seem willing to risk some uncertain outcomes for the quality of the human experience. They tend to stress the psychological benefits of self-help and the reduction of passivity. (They follow quite closely the pattern of "healthy" adaptation to life crises described by Gerald Caplan in *A Chance to Grow*.)

Functions

Both movements perform the same basic functions for their members and constituents. They offer consumer referrals to care which is sympathetic to the couple's choice. They offer mutual support in a peer group setting led by someone who has successfully preceded them in the desired experience. All groups offer their own preparation programs designed to serve as an information-giving setting, a psychological rehearsal for maximizing the quality and safety of the experience, and a source of mutual support. Both movements have used professional people as resources although each movement gradually produced a new worker and a new training program designed to prepare her (usually) to fulfill the unique goal which the movement is attempting to achieve.

New Workers

The training of the childbirth educator has always been broad and interdisciplinary. What began as an advocate role for the woman alone was gradually transformed into a liaison role between couple and institution, with the advocate role shifting to the husband or a specialized labor coach. Currently, the childbirth educator is functioning as more and more of a handmaiden to the physician and an advocate for the goals of the institution, particularly as hospitals increasingly offer classes competitive with prepared childbirth movement classes. The advocate role, meanwhile, is slowly being assumed by the home birth movement as the husband and labor coach are increasingly co-opted by the childbirth educator and the institution in hospital births. In the case of the home birth movement, the new worker is the lay midwife, who not only trains the couples but also assists the woman in the delivery of her baby (a replacement role never

assumed by childbirth educators, who function in a complementary role only). As the home birth movement grows, the knowledge, training, and skill of this new worker grow increasingly complex and specialized.

New Knowledge and Skills

Each movement has gradually uncovered and created a new body of knowledge, which is still growing. In each case, the knowledge is being shared openly and willingly with lay people and with interested apprentices and professional people. In the case of childbirth preparation, the subjective experience of labor and delivery gradually found a systematic language which did not exist in the medical literature and is not considered relevant to orthodox medical management even to this day. As this language and the physiological and psychological concepts on which it was based became still more systematically developed, special tools and skills were developed around them. The woman in labor and those supporting her could use these to enhance the experience and increase the likelihood of a good outcome without denying the individuality of her experience. Although it has always included physiology, this knowledge has expanded primarily in the psychological direction, incorporating a variety of insights about the social and psychological context in which labor and delivery occur (e.g., the dynamic of the couple, the group experience in classes, the hospital atmosphere) and how this may impact on the progress and outcome of the birth itself. Lay midwives, on the other hand, are gathering new knowledge about prenatal care, particularly the role of nutrition and exercise in preventing many common conditions.* They are also presently amassing data about what occurs when women are not moved from their own environment during labor, and when there is no routine medical interference in the absence of physical indications. This information is both physiological and psychological. As the childbirth educators rediscovered the subjective experience of labor and self-help tools, lay midwives are rediscovering preventive measures and the normal optimum progress of pregnancy, labor, and delivery.

*It is interesting to note that the focus on nutrition and exercise during early pregnancy was important in the early "natural childbirth" programs developed by Grantly Dick-Read followers, but was dropped by Lamaze enthusiasts, who favored concentrating on labor and delivery during a shorter period and leaving the prenatal care entirely up to the physician. Other countries and the World Health Organization have classically defined public health in maternal and child health as preventive health care which stresses these factors, rather than crisis care and massive intervention at the time of birth.

Contributions to Health

Each movement inadvertently contributes to improved long-range infant (and maternal) outcomes. While early prepared childbirth people were concerned about the effects of routine medication on the behavior of the newborn and were among the first to question the medical safety of its use, their reasons were partly psychological; they did not have the hard biological data which is available today to verify their doubts. Thus those who insisted on little or no medication were likely prevented a certain level of risk or damage. Similarly, evidence is already becoming available indicating the short-term risks involved in many of the newer routine interventions and newer anesthetics in normal hospital birth today. Again, while the primary motivation of those involved in home birth is often to provide a more human and humane experience, they are equally concerned to maximize the safety of these births. The less intervention, the less need to control or counteract the results of those interventions with still other risk-enhancing procedures. In this way the true nature of the uninterrupted process of labor is being discovered, and thus far the consistently superior outcome is one of the remarkable features. It remains to be seen whether this outcome is a function of the group which selects itself for home birth or something inherent in home birth management or both. However, matched

data showing the comparison between normal labor at home and normal labor in the hospital would be easy to obtain and should be available soon. Earlier studies of high-risk women in Appalachia who were screened and in most cases delivered at home by nurse midwives demonstrated long ago, however, that home birth need not be restricted to normal, low-risk women.

Technology

The prevailing medical technology and hospital practices themselves have probably been one of the decisive factors in the creation of both movements. In the late forties and early fifties "twilight sleep" was at its peak, and standing orders were routine in most hospitals for the vast majority of women. In a sense it was the very rigidity of that system, its absolute failure to individualize, and the totality of the removal of both consciousness and memory that created the climate of readiness for an experience in which the woman could realize her own unique birth and see her own baby born. After an initial period of enthusiasm following the first Yale study (1951), the "natural childbirth" movement was driven underground by the opposition of physicians and obliged to organize and systematize in order to work for these goals. The husband and father eventually became the innovation and key in this process, both because of the economic power which he represented and because of the psychological and moral support—the advocacy—which he offered the woman in the hospital environment. The terms "prepared childbirth" and "Family Centered Maternity Care" were then developed.

It had been a standing hospital rule in early prepared childbirth programs that fathers would not be allowed during labor once medication was given, since the initial doses at that time were so large and it was assumed that progressively greater doses would then be given, ultimately rendering the presence of the father irrelevant. This rule put considerable pressure on prepared childbirth couples to avoid all medication since at first only prepared fathers were allowed in labor. Many women felt threatened by the totality of no medication and anesthesia but knew that if they took any medication they would lose their husbands' support and be obliged to accept anesthesia and all of the other procedures as well. Thus, the "success/failure" syndrome, the rigid dichotomy of "natural childbirth" was created by the prevailing American hospital practices. Successes were not many, for any total refusal of the technological and pharmacological armamentarium (medication and anesthesia, forceps and routine minor surgery) was still anathema to most physicians. In an effort to help parents avoid an all-or-nothing dilemma and to present physicians with a less rigid program, elements of the prepared childbirth movement began suggesting a reduction in prevailing amounts of medication, rather than no medication at all, as an acceptable compromise during labor. While the idea of negotiating these amounts was new to both parties and not universally welcomed by physicians, it did make preparation programs more acceptable to everyone and helped establish negotiation as a new model of interaction between patient and physician. After lengthy conflict the rigidity of the hospital system gradually relaxed, making room for individual variations in the amount and kind of medication and in the number and identity of supportive attendants—all usually dependent on the absence of anesthesia, however.

The hospital rule against husbands in delivery was similar in origin to that against husbands in labor. Once a woman was both medicated and anesthetized, a husband could only be an observer to a procedure. Therefore, once there was pressure on hospitals to include fathers in delivery, there was a simultaneous pressure on both the couple and the doctor to avoid anesthesia. The development of continuous regional anesthesia and the need for large normal populations on which to perfect the experimental technique made the last change in the rules possible. Hospitals suddenly began to include fathers whether or not they were prepared and whether or not the mother was receiving anesthesia. The need for special classes to prepare couples was thus minimized, though classes of all kinds had become a popular and

important adjunct to childbirth in the minds of most middle-class couples. The differences between prepared and unprepared couples, which had been diminishing over time, were now even less recognized.

The emphasis in hospital childbirth education classes has gradually and inevitably moved toward a preparation for the usual events and procedures at that hospital rather than for each couple's unique experience. As a result, the numbers of women having epidural anesthesia in teaching centers is rising sharply among all groups—those prepared in hospital classes, community classes, or unprepared. As the difficulties inherent in the epidural procedure have become better understood, further interventions and more routine use of the fetal monitor and oxytocin stimulants to counteract these problems have been instituted. Finally, as these interlocking systems begin to produce crises with greater frequency, the caesarian section rate begins to rise higher and higher among the population of normal women at the best teaching hospitals. Women who protest these procedures are once again being subjected to considerable pressure to conform to their routine use, including legal releases and overt warnings that they are risking their babies' lives.

Thus we have come full circle. Standing orders, so carefully abolished as bad medical practice of the fifties, have merely been reinstituted under another name. The increasing rigidity and standardization of medical practice and the escalation of invasive mechanized technology have once again narrowed women's options to the point where deviance from conformity to the prescribed norm brings on concerted pressure, all in the name of safety. It can be argued, then, that women whose options become too narrow will create alternatives when their individuality is threatened. The home birth movement, like the natural childbirth/prepared childbirth movement, has been created in large part as a response to the current wave of rigidity and routine intervention. It is also to some extent a response to the failure of the earlier movement to effect fundamental reforms in hospital birth: the father is included rather than excluded, the mother is awake rather than asleep, but after twenty years anesthesia and forceps are still used in the overwhelming majority of cases.

Economics

The second decisive factor in the creation of both movements is economic. Both movements have discovered that rational argument and even scientific data prepared and presented by reputable colleagues is not as effective as economic pressure against the resistance to change of physicians and hospitals. As the demand for prepared childbirth rose (while the birth rate declined), physicians discovered that it was the middle-class private patients from whom they expected to derive their income who were demanding this program. Once organized, the movement could direct these patients away from elite or resistant physicians and hospitals to those smaller complexes and flexible doctors that would respond to their needs. This is also becoming true of home birth. It was this realization more than any other which eventually caused the larger institutions to capitulate, in form if not in substance, to the prepared childbirth reform demands of their preferred clientele. In the case of home birth the economic drain is not yet great enough but it may become so.

Working With Professionals

The relationship which these movements have had with medical experts and other professionals has been similar in several ways. The ideas of "natural childbirth" and home birth seemed to catch the imagination of women all out of proportion to the amount of leadership from health professionals in the United States. Each movement has looked first to European doctors or midwives for inspirational philosophy of professional experience on which to base its claims. To some extent each has also tried to reach back to an idealized part in history or human development when the particular mode it is seeking might have existed in its pure state. While both movements have been grateful for whatever support they could find within American medicine, this support has rarely come from elite specialists, who tended to disparage the responsiveness of their more ordinary colleagues, in many cases

professional pressure was brought to bear on the hospital appointments or on the practices of cooperating physicians. Both groups, as they have developed, have relied on physicians' technical knowledge and their willingness to selectively endorse certain issues, but for the most part the kind of collaborative relationship that would come naturally out of a joint working environment has not been formed. The locus of both movements has been in the community as opposed to the hospital (although much prepared childbirth has related to the hospital). It has tended to be nonmedical experts who are the greatest sources of professional support: behavioral scientists, teachers, lawyers, clergy, and others in the helping professions.

The similarity between these two movements in their relationship to professional people ends there, however. Prepared childbirth workers instinctively formed local and national groups using middle-class models of nonprofit voluntary organizations and utilized medical professionals as consultants. The home birth approach has been different (see Difference).

Professional Resistance and Consumer Response

Each movement has discovered certain characteristic patterns of response from physicians and institutions with which it has tried to work: these response have included social, psychological, and legal pressures. As indicated earlier, the first response to women's requests for "natural childbirth" tended to be dismissal, humoring, or "exceptionalizing," followed by considerable cajoling or outright pressure on the woman to conform to the prevailing pattern of care. This pressure took several forms, the first being labeling—overt or covert, categorizing of the request as deviant, bizarre, or neurotic and even psychotic. (In the fifties, this pressure became more systematic and took the form of elaborate psychiatric studies, offered as "proof" by psychiatric colleagues. The same requests in the late sixties and seventies were rejected by mental health experts as evidence of mental health.) Threats and intimidation through anecdotes and exaggerated descriptions of what could or would happen if the patient persisted (see *The Childbirth Challenge* by Waldo Fielding, 1964), along with lies—that is, deliberately promising patients a spontaneous birth without sincere intent to comply—were other tactics. The most coercive forms of professional resistance included refusal to give necessary care if couples received preparation, refusal to sign permission forms for patients to attend preparation classes, and charging exorbitant sums of money to work with prepared couples. Once the demand rose to a certain level and fathers became involved, professional resistance also became better organized. In some areas articles were circulated privately among chiefs of staff and hospital administrators urging solidarity in opposition to preparation classes and fathers in delivery. In many cases flexible institutions and physicians were put under effective pressure from their peers to become more rigid and to deny services and accommodations they had previously provided. In some areas (e.g., Boston and Springfield, Mass.; Madison, Wis.; Colorado Springs Co., Austin, Texas) parents were forced to travel long distances to deliver at hospitals which were flexible. In several cases their own area hospitals successfully brought pressure on the flexible institutions to deny these couples service.

In an attempt to deal with these pressures, parents tried to develop tactics of their own. Fathers were occasionally arrested for refusing to leave hospitals and delivery rooms, and they filed counterlaws. In rare instances they handcuffed themselves to their wives so as not to be separated from them at birth. They also sued hospitals in advance (successfully and unsuccessfully) for their rights to attend their wives during delivery. Currently, legal pressure on parents in hospitals is taking the form of requiring parents who refuse routine interventions to sign forms releasing the hospital from responsibility should any problems occur later—a procedure which, though illegal, is highly effective. Most parents resent the coercion and abandonment implied in this procedure.

In addition to the pressure brought on parents, pressure was also brought on childbirth educators. If they were nurses, they endured peer pressure as "bad" or deviant nurses both because

they worked in the community for parents rather than hospitals and because they so frequently questioned rather than obeyed doctors' judgments and orders. Occasionally they were prevented from working in a hospital with parents they had prepared unless the nurses were employees of that hospital. As nurses in the hospital attempted to make hospital care more flexible, they were frequently obstructed and in many cases lost their jobs. With lay instructors the problem was simpler in some ways; they were simply denied entrance to hospitals to support their prepared students and frequently their credentials were challenged even when they had Master's degrees or Ph.D.'s).

In the case of the home birth movement, the pattern has been very similar thus far. Physicians refuse outright to deliver women at home, which is certainly their privilege. However, the home birth lay midwifery movement in parts of California was essentially created in response to the rigidity of the physicians and their institutions. Prepared childbirth was not accepted by the hospitals and physicians; women determined to have a prepared childbirth felt they had no choice but to deliver at home. When physicians refused to give prenatal care to women who had decided to give birth at home, the women became obliged to seek prenatal care and birth attendants elsewhere. In this way the lay midwifery movement and a specialized service, the Birth Center, began. However, once the incidence of home birth and the level of demand for it reached a certain critical economic and social point, physicians reacted by moving to bring legal actions against the midwives for practicing medicine without a license. While no judgment has yet been made in these cases, if the findings are against the midwives, parents are prepared to file a class action lawsuit against physicians for having denied them prenatal care. Other coercive tactics, such as withholding insurance reimbursement, have already been used by medical groups and counterattacks are being planned by consumer groups. It is also being suggested by some professionals that failure to seek hospital care for birth be made an act of criminal negligence on the part of the parents, thus extending the concept of legal coercion.

Thus if the pattern of the fifties is relevant, the period of maximum resistance to the home birth movement (including legal pressure on both sides) is just ahead. While the movement is small now and the "either/or" choice which it implies is very hard for most women, just as it was in the fifties, the increasingly systematic preparation and study and the competitive statistics of home birth will undoubtedly begin to have an effect, especially alongside escalating hospital technology, costs, and physicians' fees. The innovations are harder to predict. Some of them will probably come from the hospital, which may begin to create "exceptional" patterns of care for highly motivated patients who would otherwise not come at all. Others will probably come from consumers in the form of some Birth Centers like the one at Santa Cruz, and probably some attempts to simulate Britain's "flying squads." Lay midwives, meanwhile, will probably increase very rapidly and will gradually gain greater acceptance, which in turn will probably tend to make them more conservative. Indeed, some California physicians have already delegated prenatal care to them.

Differences

While the prepared childbirth groups were reformers trying to work within the existing system and did not challenge either the locus of birth or the basic economics of it, home birth groups are convinced that childbirth must be deinstitutionalized and that the enormous (and still rising) costs of hospital births for normal cases are not necessary. This is the most significant difference between the two movements. While prepared childbirth groups felt that the obvious superiority that the hospital birth provided in safety to mother and baby put home birth out of the question, the home birth groups are increasingly growing to feel that home births for normal couples may be equal and even superior to hospitals where safety is concerned (see *The Inevitable Deception* by Susanne Aron, Houghton-Mifflin, May 1975). Boston home birth fees are less than half the cost of hospital births. The proposed regionalization programs (which promise to be even more expensive than our present system) will generate additional costs

which will rarely be passed on to the normal consumer of hospital care.

From the viewpoint of medical professionals, the immediate threat of the home birth movement is twofold: (1) that our already poor infant and maternal mortality figures will worsen, and (2) that the economic loss created by the dropping out of the most normal patients will drive the costs of caring for those who must remain in the system to an excessive extreme. These are threats of a magnitude not generated by the prepared childbirth movement. Deinstitutionalization offers other threats to both the physician and the hospital personnel. In the hospital setting the social control of patients, and thus the ultimate medical control, lies with the agents of the institution. To maximize control has been the goal of hospital birth since its inception; the focus has merely shifted from decade to decade, first onto control of infection, then onto control of maternal mortality or maternal pain or the progress of the infant out of the mother's body, and now to control over the rate of labor and the stabilization of the infant during the first twenty-four hours. Regionalization, for example, has as its ultimate aim the control of the infant mortality rate. To shift birth into the home threatens social control absolutely and thus threatens medical control over every medical objective, including the current one.

Another difference between the movements lies in the convergence of the home birth movement with the women's movement. In the fifties there was no social context in which it was appropriate for women to protest. This further contributed to the tendency to label women interested in natural childbirth as deviants or social misfits. Today there is a ready-made women's movement ideology into which home birth fits easily. It is because the percentage of women of childbearing age who are having babies is smaller than at any time in the century, many of these women feel isolated; women in the home birth movement can feel a solidarity with other women's efforts and other protests going on in the women's movement, particularly the women's health movement (though not all of them necessarily do). However, the women's movement commitment to the belief that women have a right to control their own bodies runs directly counter to the longstanding role of the prepared childbirth movement, namely, that the doctor has the final responsibility for birth. Feminists and nonfeminists alike are increasingly resolving this contradiction in favor of the woman, realizing as they do so that there are many women who are not willing or not ready to take on the responsibilities for their own childbirth experience. Yet, feminists argue, as knowledge of patients' rights to informed consent and self-determination becomes better understood, the traditional role of the doctor even in the hospital setting must be increasingly challenged. Finally, as the damaging evidence against the best accepted hospital practices of the fifties and sixties continues to be published, it becomes imperative that the unnecessary and essentially experimental nature of much contemporary hospital practice be acknowledged and questioned. If women do not take that responsibility, no one else will.

This is the greatest point of divergence between the two movements: While the prepared childbirth movement was ready to reduce the importance of the physician in the total outcome of the childbirth experience and described him frequently as a member of a "team," there was never any question that he was the captain of that team. It is questionable whether the team concept, including the parents as members of the team, has ever truly functioned in more than a dozen settings, but as an ideal to be strived for it has been carefully retained. To parts of the home birth movement the physician is in many respects even more important than in the hospital, since his skill and judgments may be used to a far greater degree when the massive technology is absent. However, this is only true when he is present. Since only a very few physicians will attend home births, and their number is not likely to increase, a woman's decision to have her baby at home will involve increasing amounts of responsibility. And in the case of the lay midwife or in self-attended births, the physician is eliminated altogether. The woman takes maximum responsibility, although she is expected to need help and to ask for it from those

around her. Since physicians have not even wholeheartedly implemented the nurse-midwifery team concept, they are hardly likely to endorse a principle which eliminates them altogether, except for some complications and emergencies.

That home birth can be seen as part of the women's health movement, as an expression of the ideology of the women's movement, and also as the next step in the twenty-year-old consumer struggle to reform maternity care. As such, it offers the potential of unifying different groups of women who are similarly opposed to absolute medical domination of the birth experience and wish to reclaim it, in whole or in large part, for themselves. Some innovations will probably come from the hospital, which may begin to create "exceptional" patterns of care for highly motivated patients who would otherwise not come at all. Others will probably come from consumers in the form of more Birth Centers like the one at Santa Cruz. Lay midwives, meanwhile, will probably increase very rapidly and gradually gain greater acceptance (which in turn will probably tend to make them more conservative). Indeed, some California physicians have already delegated prenatal care to them. Home is the one place in which the potential to achieve the goal of reclaiming the birth experience seems greatest; there will probably be some attempts to simulate Britain's "flying squads" as backup for home births. The deinstitutionalizing of childbirth and very strong resistance to it seem now to be a certainty, however long it may take. A new chapter is already being written in the history of American midwifery. It is an idea whose time has come again.

A Summary of the Ideas Presented by Birth Day

BIRTH DAY is a group that offers support and resources to women who have decided on a home birth or who are exploring alternatives to and within the hospital. We are committed to making it possible for women to have real choices about how, where, and with whom they birth. BIRTH DAY holds open, monthly meetings and offers "The Birthing Experience," preparation classes for childbirth. The support we find in meeting together enriches the pregnancy experience and makes choice more possible. We are re-learning our bodies and our natural functions, including what natural, normal birth can be like. We are learning more about our feelings during pregnancy and childbirth. We believe in women's ability to deal with pregnancy and childbirth in a positive, natural and creative manner. Women can make responsible choices about how they birth based not upon "pain vs. no pain" arguments, but upon the best interests of self, newborn, and family.

Our experiences tell us that for the normal, healthy woman home can be the best and safest place to birth. By giving birth at home we often are most able to take control of and responsibility for our own bodies and lives. There, with those closest to us, the emotional and physical well-being of both mother and newborn can be given highest priority. There is space, time, and respect for the natural rhythm of the birth process as well as the personal wishes and needs of the birthing woman.

We feel that homebirth should be a choice for those who want it, without penalty or unnecessary risk. There should exist fully-equipped mobile maternity vans to be on call in case of emergencies. This is no small demand, since acknowledging and meeting this need involves redesigning existing maternity services and priorities. If money is available to provide expensive mobile units to transfer high risk infants from one facility to another, there also should be money to provide backup for the rare emergency that might occur at home. As part of the consumer community we feel that women deciding on homebirth have a right to this service.

We need to move in new directions away from the existing medical emergency, pathology approach to birth that seems to be increasing with the advent of the "new technology"—epidurals, fetal monitors, etc. Homebirth should not be the only alternative, either. We would like to see the development of maternity homes, where women could go, give birth in pleasant non-medical

surroundings, and leave when they are able—places where disruption of family patterns would be minimal.

More and more we are wondering if birth is in the hands of the wrong people. We see the attitude towards birth as medical emergency, the insensitivity towards the best instincts of women, and lack of concern in hospitals regarding the separation of infant from mother as not unrelated to the predominance of men in obstetrics. Our concern is not that obstetricians do not know how to intervene when a real emergency arises but that they have learned to intervene all too often when there is no problem.

Therefore, we support the legalization of midwifery, a profession rooted in a deep faith in and respect for the process of birth and in a kinship with women. Women should have the choice of being assisted by women and by midwives in their birthing.

We also see the need to ease consumer pressure on doctors and hospitals for immediate changes: laboring-delivery rooms, no arbitrary separation of mother from child, possibility for inclusion of members of the family other than father. Yet we question how much real effects these small changes will have. We also need to re-examine the very language we use: doctors do not deliver babies, women do; doctors do not provide prenatal care, women do; mainly, doctors screen for difficulties.

Birth, like death, is one of the peak experiences of life, for mother, for mate, for child. In our culture, the new technology has often caused many painful and harmful ruptures in the birthing experience. We want to make it possible for women to take that experience back as a happy, healthy and natural one.

Appendix to Issues Surrounding Contemporary Birth Practices

Since "regionalization" of maternity and newborn care was an important focus of several of the maternity workshops, some detailed discussion of this topic follows:

1. An excerpt from material prepared by Norma Swanson:

The Regionalization concept is derived from guidelines developed by a group called "The National Committee on Perinatal Health," through funding provided in part by the National Foundation/March of Dimes. Members of this committee are: The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice, and the American Medical Assn. No representatives from the specialty societies of other pertinent groups were invited; therefore, there is no participation from the American Psychiatric Assn., nor from the non-medical professions concerned with childbearing in hospitals, such as the American Nurses Assn. or the National League for Nursing, nor from the National Assn. of Social Workers. (It is a noteworthy fact that there is not one woman or non-physician member of the entire 14-man committee.)

The regionalization concept is a systematic effort to lower the infant mortality rate in a period of declining births through the use of extremely high technology applied routinely at the time of birth. Crude screening of "high-risk" mothers is implied, but in fact there is no mechanism to guarantee that such screening will be carried out by the obstetrician during the prenatal period. Screening by private physicians and even by pre-natal clinics is in most cases voluntary. Therefore, in addition to the assignment of identified high-risk mothers to high-risk centers, a complex system of transfer of babies in difficulty after the birth is presumed. The costs of both the high-risk centers and the transfer capabilities are estimated to be at least 2.6 million dollars annually (this figure is the late 1974 estimate for the cost of an intensive care unit alone for 1000 newborns.) Since it would be economically impossible for units already operating at a loss to sustain this added investment, the regionalization of hospital facilities with these capabilities becomes a necessity. In addition, studies of perinatal outcome have led to the establishment of criteria for minimum number of births annually in a hospital maternity unit. This number was originally set at 5000 births, but has since been revised downward in Mass. to 900-1200. Other studies show

higher infant mortality in larger centers. Until recently there has been little systematic planning. The regionalization effort in Mass. would divide the state into regions, each serving an estimated 8,000 to 12,000 live births annually. Each region could potentially have three levels of hospitals, as follows:

Level I Hospital would primarily provide prenatal and perinatal services for (presumed) uncomplicated obstetrical patients and newborns. However, in actual practice there will only be one such facility in Mass., on Martha's Vineyard, due to geographic isolation.

Level II Hospital would provide prenatal and perinatal services for (presumed) uncomplicated obstetrical patients and newborns, as well as services for a certain level of complications among women and newborns. A level of specialization between and among Level II hospitals is expected. Level II hospitals are presumed to have the capability to recognize and transfer newborns in need of ICU services to the regional Level III hospital. However, no transfer of healthy mothers with sick newborns is presently being planned.

Level III units will provide care for both normal patients and for all types of maternal-fetal and neonatal illness or abnormality. These will be high-risk Perinatal Centers with ICU capability, almost exclusively large teaching hospitals, many of them single specialty hospitals without the broad resources of a general hospital. These centers, in order to maintain the annual quota of births for optimal functioning, will contain Level II hospitals within the Level III designation, since the treatment of high risk cases alone is unlikely to reach that figure.

Comments?

1. Despite a twenty-year history of medical literature from ethnology, pediatrics, psychoanalysis and psychiatry, demonstrating the mental health needs of mothers, babies and now families, there is no evidence that this literature was consulted or incorporated into the Regionalization concept in any way. On the contrary, there are no plans to transfer mothers and babies together, not to guarantee that social services or mental health consultation will be available to the transfer families at both the smaller and larger hospitals. Studies in progress at the Harvard School of Public Health have already demonstrated the considerable stress which results from the transfer crisis, even under the limited Regionalization presently implemented. Fathers may need to circulate between older children at home in one community, a wife in a maternity unit at some considerable distance from home, a sick newborn at an even greater distance, and a job which is likely to be in a fourth community. Mothers planning Rooming-In and/or breastfeeding may not be able to see their ill or premature newborn if there is a transfer to a distant hospital while the well mother is left behind in the delivery hospital. The new mother's condition may delay her discharge, again preventing early contact with her baby. There are no provisions whatever for the care of babies born at home or in birth centers, a growing trend in Massachusetts and other parts of the country. The National Association for Mental Health has prepared a position paper on the importance of Primary Prevention in maternity care. Under the Regionalization program, there is no planning even for tertiary, crisis mental health care at childbirth, let alone an opportunity for such primary prevention. The Comprehensive Health Planning mandate originally included "physical, mental and environmental health."¹ However, in Massachusetts the mental health planning was presumed to be being done by the already regionalized Department of Mental Health (DMH). It is a major problem in health policy that there has never been any coordination between the DPH, the DMH and the EOHHS (Executive Office of Human Services) in Mass. on the mental health needs of childbearing families, or either the primary, secondary or tertiary care levels. This problem is also a nationwide problem. Only the MAMH paper and the work of consumer groups at the national and local level have even identified the problem, again, despite the wealth of both medical and behavioral science literature (to say nothing of the large popular literature.)

2. There has been no consumer input into the planning of the Regionalization project, despite the existence of at least 20 consumer groups working within the state to improve maternity, newborn and pediatric care. The Comprehensive Health Planning (CHP) agencies, which require 51% consumer membership, did not involve consumers in the decision-making, but restricted participation to staff members who conducted the utilization and service area studies. At the CHP-sponsored public meetings, there were no consumers represented on the program, and no mechanism for registering or incorporating the considerable consumer protest. Again, this is a major policy question. To consumers of maternity services are women. Of the twenty-six Public Health Service Programs of the HEW, only Title V, Maternal & Child Health, has never had a mandated, local citizen or consumer advisory board required. Hospitals, which determine the policies for maternity and newborn care, have never been required to consult users, consumers and local citizens. The DPH, which sets the Regulations for hospital services, are physicians, and have restricted public input to the required public hearings, called long after the major policy lines have been determined, and poorly advertised. The CHP "..." agency has sharply limited the input of its planning committees to those aspects of planning which have a direct economic impact; other consumer issues have no place.

3. There has been no in-depth economic analysis of the Regionalization program, and no exploration of alternative methods of allocating the exorbitant sums required to achieve the same end. In fact, the original goal of the CHP legislation, which intended a reduction of spiraling costs through the development of alternatives, including primary care, preventive services and expansion of ambulatory health services, may be shown to be directly defied by the Regionalization project. In terms of actual cost-benefit, there is no evidence being gathered to question the assumption that Regionalization will either reduce costs of the present system, or improve outcome. (A Johnson Foundation study will make a limited examination of this question.) While the report of the Regionalization committee acknowledges this, there is no plan to explore the implications in Massachusetts prior to implementing the Regionalization project, even through such implementation implies the commitment of vast sums of public and private money. The abundant literature on the significance of the prenatal period for the outcome of pregnancy has not been acknowledged sufficiently in the project.

4. There is an acceptance of the current rate of high-risk mothers implied in the Regionalization project. It has been admitted that this is instead of attempting to lower the number of high-risk and at-risk women through primary prevention. In modern countries where infant and maternal mortality are far lower than ours, even when adjusted for our high-risk urban populations, the use of midwives, food supplementation, family allowances, education and domiciliary delivery have been directly credited for the superior outcomes. The medical experts who are our policy-makers in maternal and child health have not acknowledged the economic, public health and mental health value of these approaches as contrasted with our own.

B. An excerpt from a report by Robbie Pfeiffer on a conference sponsored by the American Foundation for Maternal and Child Health and entitled "Obstetrical Intervention and Infant Outcome, Implications for Future Mental and Physical Development" (see BACE Newsletter, July-Aug. 1975):

Peter M. Auld, M.D., Professor of Pediatrics, Obstetrics, and Gynecology at the New York Hospital-Cornell Medical Center, represented the forces working to implement consolidation and regionalization of maternity care services in the United States. He described regionalization as a nationwide scheme to improve care of the high risk infant and mother. He said there were four basic elements of regionalization which needs to be understood. First, routine screening methods during pregnancy such as amniocentesis, ultrasound, and monitoring would be performed to detect the high risk case (50% can be anticipated in advance.) Second, the problem of an at risk fetus would take precedence over

any other concern and may be the overriding concern. Third, newborn infants at risk would be identified immediately and transferred to neonatal intensive care units. Fourth, not all doctors will or should have the capacity to deal with the high risk case.

Dr. Auld described regionalization as organization—by integrating services the perinatal mortality and morbidity can be reduced. He showed a slide of a chart which outlined the structure of a regionalization program. At levels 1 and 2 of a 3 tiered system would be community hospitals which would provide both private and clinic maternity services to a local population and would assess high and low risk pregnancies and be expected to perform 1500 deliveries annually. Level 3 hospital, the perinatal center, would provide the following services: normal obstetrics and newborn care, high risk obstetrics (in-patient and out-patient), neonatal intensive care, monitoring, laboratories, research and training, transportation systems for high risk babies, evaluation of outcome, follow-up, and data processing. Doctors in community hospitals would consult with specialists in the regional centers and refer infants and mothers to them. The Level 3 hospital, in order to justify costs, would be expected to have a census of 5000 deliveries annually.

Dr. Auld stated that regionalization only operated in a few places at the present time and called on the government, the medical community, and the public to support it. He said the government did not place funding for regionalization in a high priority category. He pointed out that it costs a great deal to care for impaired children, and the federal government presently supports programs in this area of health care. He suggested that government money go into regionalization as a preventive measure against future problems. The point was raised by the audience that money should go into primary prevention programs rather than regionalization, to prevent problems before they arise. Dr. Auld said many obstetricians were still resistant to the idea despite the fact that major medical societies have endorsed the plan.

Dr. Auld stated that home deliveries should be condemned, an attitude which reflected remarks of other advocates of regionalization who have suggested that having a baby at home should be made an act of criminal negligence. Dr. Auld was criticized by members of the audience who said that regionalization should include the option of safe home births. Denis Haire disagreed with Dr. Auld stating that domiciliary care, carefully planned and managed home births, is a desirable pattern of maternity care and would provide an opportunity for young physicians to learn what normal childbirth is really like.

Dr. Auld called on third party carriers, like Blue Cross-Blue Shield, to take an interest in the regionalization program. Dr. Auld echoed ideas expressed by a powerful figure in regionalization, George Ryan, M.D., M.P.H., Harvard Medical School Professor and Director of Ambulatory Services and Community Health at the Boston Hospital for Women, who sits on the national foundation Committee on Perinatal Health, which planned the regionalization program sponsored by the National Foundation/March of Dimes. Dr. Ryan said that coverage of high risk mothers and babies should be provided (maternity care is inadequate in most health insurance plans) with reimbursement conditional on the patient using the high risk facility. No provision for needed coverage of the low risk patient was mentioned by Drs. Auld and Ryan. Both issues, home births and third party payments, show how legislative and economic pressure is brought to bear on the childbearing population narrowing options (for those who even have options) to conform to schemes drawn up by providers without participation (other than token) of recipients of health care.

Dr. Auld was puzzled by what he perceived as a lack of consumer interest in the plan, suggesting that the "ladies auxiliary, PTA, and women's lib" should support regionalization, a remark which produced several angry responses from the audience. As he was puzzled, so were many in the audience by the fact that Dr. Auld had never stopped to consider that this approach to obstetrical care was only an answer rather than the answer, and perhaps not the best one.

There are many reasons why the regionalization plan raises as many concerns as it seeks to solve, and some of these were voiced by the audience. While health planning is crucial to rational delivery of health care, removing services from neighborhoods and replacing them with centralized centers may not be the answer. Good planning can also work on a decentralized model depending in some measure on whether the emphasis is placed on primary prevention programs and continuity and comprehensibility of care or whether emphasis is placed on secondary or tertiary levels of prevention where centralization becomes necessary to avoid excessive costs in the accumulation of expensive equipment and highly skilled personnel. Fragmentation of health care must be eliminated, but this does not necessarily dictate regionalization. Neither Dr. Auld nor any other spokesperson for regionalization has ever given any voiced consideration to the importance of treating individuals in a family as part of a unit, or to treating families within the context of the community. The data presented at last year's conference by Dr. Marshall Klaus on the importance of extended family contact with the newborn following birth has never figured in to discussions on regionalization. Localization of care does not mean fragmentation, regionalization does not mean unification. In fact the evidence presented seems to suggest that the opposite is true.

Dr. Wegman's suggestion that we become Number One in health care rather than the military certainly reflected a wish of all who gathered to speak at or to attend the conference. Unfortunately the plan to reduce infant mortality in the U.S. laid out by Dr. Auld all too closely resembled military strategy with emphasis placed on technology and its characteristic defensive posture, "mistakes for peace," to the exclusion of philosophic and humanistic considerations.

WORKING IN HOSPITALS

by Karen Norberg

Health work, we can say, is women's work, not only in the family but as wage labor. In the U.S. at least 75% of all health workers are women, and they dominate all but the highest levels of the hierarchy: 83% of service workers, 94% of clerical workers, 96% of nurses and 70% of technicians, but only 8% of M.D.'s and 10% of administrators. More than half of the "health labor force" are working class women who, as clerks, nurses aides, housekeepers or kitchen aides, work menial, repetitive jobs near or at the minimum wage.

What is it like for women who work in hospitals? What are the issues, where is there energy and militance for change? What models do we know of? What is the machinery of change, both inside and outside trade unions? And for this Conference in particular are there ways for the women's health movement and the hospital organizing movement to work together towards creating a new medical system?

Those of us who planned this part of the Conference organized some workshops around these questions. We naively had hoped for a consensus, for a position paper at the end, and for concrete alliances and plans for further work. Instead, we reaped a sense of confusion and discouragement. But we also left with notebooks full of important observations from the planning and from the Conference itself. Although we feel that this Conference did not really represent hospital workers, nor any other group of working-class women, and although our talk of working-class organizing often had an abstract ring, we learned some valuable things we'd like to share.

1. The Panel: A Frustrating Experience

In planning for this large panel discussion we made a list of issues that repeatedly emerged during the small and large meetings of the weekend:

- Why, despite the fact that women are by far the majority of the health workforce, we work in positions that offer little opportunity for changing how the health system works.

- The ways in which management has used hierarchy, class, race, and sex to "divide and conquer" the health workforce.
- Concerns shared by all health workers, eg., interest in serving patients better, interest in better working conditions, interest in unionization, etc. These concerns provide the building blocks for more effective organizing.

As the majority of health workers we can, if sufficiently organized, directly control the quality of care offered to patients as well as our working conditions. Some of us see an important obstacle to such organizing in that many hospital workers, especially nurses, do not identify themselves as working-class, but rather see themselves as "professional" or "semi-professional". Until we recognize that there is only one main division—between those who control the way health care is "dispensed", and everyone else who must work for a living in the health care system, with little control over what this system is like—all of us, as health workers, health activists, health consumers, etc., will not be able to organize sufficiently to bring about change.

Unhappily, the panel discussion was frustrating and unfocused according to many women there. We believe that this was largely caused by last minute chaos, inexperience, and our reluctance to take responsibility for the course of the discussion. The audience itself probably began frustrated and divided. One panel member summed up the session as follows: "I feel like we haven't learned a thing in four years."

2. Women Working with Women: "We are the gardeners".

This workshop was to be a sequel and extension of the panel, but instead there was an entirely new audience, predominantly nurses. According to Jude Gunn, one of the co-leaders, the mood was one of caution and frustration. She wrote:

"Thirteen women sat looking at the co-leaders, awaiting aphorisms and solutions to spew forth. Certainly the co-leaders expected not to be pedagogues, but instead to work with the other women at trying to define problems and seek answers..."

"...we came) back to the question of how to get people together. Meetings, clandestine or otherwise, were suggested. One co-leader discussed the need for strength sharing. That is, if one woman has a more developed consciousness than another, she can become flexible and bend to give strength to a woman who is not aware of her oppression and the sad state of our health care system. One simple suggestion was that we start talking with fellow workers about issues relevant to health care workers and ourselves as women. Communications is an important tool in achieving social change."

"Many ideas were tossed around...We would find a seemingly good tactic only to have it riddled with holes by the realities of the situation in which it was to be tested. Good discussion was achieved but spirit was low..."

"The question of how to change the health care system...cannot be resolved in one workshop or in one three day conference about health care. As with all things, revolutions need time to grow. We as people are the gardeners who provide the tools and life-sustaining substances for growth...Our surest sign of strength and growth is to live our ideas, beliefs, and desire for change..."

3. Division of Labor and Alternatives: "Class conflict is alive and well!"

This workshop of about 25 women became an open-ended discussion of class conflict and division of labor in the hospital. We were technicians, clerks, nurses, medical students, one administrator, and several women from women's health centers—there were no lowest level workers (service and housekeeping) and no Third World women.

About class: We spent some time examining why a certain woman administrator had been booted during the earlier panel discussion. Our reasoning followed these lines: that because class conflict is 'alive and well', there is a tension between so-called "paraprofessionals" (middle-level workers like most of the audience) and the professionals they work for. Feminists do not ignore the fact that class does indeed divide women.

About division of labor: In general, skills or functions have been taken away from an all-purpose, skilled, better-paid worker (a professional—M.D. or R.N.) and have been given to more

specialized, less skilled, more poorly-paid workers. Examples follow: well-baby pediatrics from M.D. to nurse practitioner; urinalysis from intern to lab technician; psychotherapy from psychiatrist to social worker; various nursing functions from R.N. to I.V. technician and nurses' aide; various clerical functions from a general clerk to medical records rooms, steno pools, and admission clerks. The bigger the hospital, the more specialization and standardization, which teaches less skilled workers to do specific jobs for lower wages. According to one article in the *New England Journal of Medicine* (Massaro, V 292 #8, p.398):

"It is interesting...that the income differentials among these groups have increased very dramatically over time. From 1949 to 1979, the growth in the approximate net median income has been from \$12,000 to \$42,000 for internists. For the same period, however, the approximate annual gross median income has grown from \$2,400 to \$5,800 for paramedicals and from \$1,300 to \$3,500 for service workers..."

We spent some time in this workshop talking about the differences between the Chinese and U.S. models for the "team system." In the Chinese model even doctors are required to sweep floors, and the M.D.'s have an ongoing responsibility to teach and train other health workers. The aim, particularly during the cultural revolution, was to break down status differences and to let each worker work to the limits of her/his ability.

In contrast, the "team" system used in some U.S. hospitals was severely criticized essentially because (except, say, for one hour Friday afternoons) the hierarchy is unchanged, M.D.'s still make most decisions, and the dead-end "job ladders" will put the lie to any "encouragement" workers hear for on-the-job training or self-education. This means that the orderly has no way of becoming an R.N., that the R.N. is given no credit towards an M.D. while on the job, and that the lab tech who asks too many questions must be reprimanded her job or bucking to replace her co-worker.

It's a great loss that this workshop went no further. We passed around no lists, we planned for no future meetings, and the potential alliances will have to wait for another time.

4. Organizing in Trade Unions.

This workshop of about 25 women began with a presentation by Sara Anderson of the Massachusetts Hospital Workers (SEU local 880) and Almada Barnes of the Hospital Workers Union (formerly "IUPW") followed by questions and answers. The audience, mostly a roomful of sympathetic, non-unionized hospital workers, had a chance to compare two of the three unions organizing hospital workers in Boston and to hear some basic union ideas and philosophy. Following are some important questions raised during this workshop:

Why unionize? For most hospital workers the main issue is not getting more money but having more control over the job. A trade union changes our legal relationship with our "boss" and enables us to establish minimum staffing requirements, limits to hours, limits to patient load, procedure rates, etc.

How do we go about unionizing? The first step is to form an organizing committee, which meets to decide which issues to organize around. The issues may vary from place to place. The second step is to decide what bargaining units to create—the whole hospital, or one unit for service workers and another for technicians, etc. This will depend on whether one group of workers is more ready for a union than another group, on whether it will be a source of strength or of weakness to divide workers into smaller units. If the hospital administrators agree to the bargaining units, this part of negotiations might take about three weeks; but if they resist, the dispute goes to the National Labor Relations Board (NLRB). Agreements can be delayed for years.

When do you call an election to bring the union in? Calling an election with only 30% of the workers signed up is usually counterproductive. Note when you think you can win. Even small things count (for example, voting on payday because everyone will be at work that day). The NLRB has many rules about what the workers and the bosses should and should not do.

How do hospitals break unions? There are three basic tactics: divide and conquer; delay; and confuse. Particular techniques include:

- Sending individual letters to every worker describing how personal freedoms are lost by joining a union, how expensive dues are, and how union leaders are really crooks.
- Assigning supervisors a certain quota of workers to drop hints to each day; the hospital has all day to talk to workers, but the union only has off hours.
- Trying positive action (e.g., firing people for petty reasons). However, there are ways to prevent this either by collective actions or by appeal to the N.L.R.B., if you can prove you were fired for union organizing.
- Trying the liberal approach, i.e., giving bonuses and raises during a union drive, in order to show that a union isn't necessary after all.
- Delaying or preventing elections through long N.L.R.B. hearings or jurisdiction, bargaining units, or other things.

How is an election achieved as soon as possible? If the workers are motivated, they can get an election faster. At University Hospital 1199 said to everybody one day: "Today we will walk pick over to the boss's office, tell him we want a union, and eat a piece of candy from that bowl he has on his desk." All day long there was a stream of people in and out eating his candy; they got the election. The point of pressure is the employer, not the N.L.R.B.

What happens after the election? You prepare to bargain, but you have to be organizing all the time. Grievances can mean tragedy (e.g., an angry worker may take it out on the patient), so organizers must be able to produce, to find ways to make an enforceable contract. For example, in order to control staffing, there could be an economic penalty for understaffing, or a specific minimum number of workers could be established. Because the hospital administration usually doesn't listen to L.P.N.'s or aides individually, it is important to develop a committee to study and recommend changes.

5. Organizing Outside Trade Unions.

This was a presentation by Transfusion, a Boston organization of hospital workers which has decided to support only one hospital union in Boston (1199). They also work through independent workers' organizations that parallel union efforts in their hospitals. Following is their self-description (from "Unions and Hospitals: A Working Paper"—see Resources):

"Transfusion is a group of people who work in hospitals. We see our primary commitment to be organizing non-professional hospital workers to take control of their jobs. We view our work in hospitals as part of a larger, developing movement to reorganize the entire society towards socialism.

Unionization is an essential part of our organizing. However, we believe unions to be limited in what they offer working people, so we see the need to develop new forms of organization that work with the unions yet are independent of them. This is a priority in our work.

We are committed to fighting against racism and sexism: the institutionalized racism and sexism that structure our lives and the racist and sexist attitudes held by people we work with.

We feel working collectively, being supportive of each other and being able to appreciate and criticize each other have been fundamental in helping us to develop as people and as organizers. We believe that these principles should be incorporated into our style of organizing.

Write us."

OCCUPATIONAL HEALTH AND WOMEN

Since the Elveter never went home—she has been working since before WWII and she's just about ready to retire. Furthermore, she and her younger sisters now make up about 40% of the workforce and like their working brothers, their jobs make them sick.

At the Conference the following workshops about occupational health were held:

- Occupational Health as an Organizing Tool (general introduction by two women from the labor group at Urban Planning AID).
- Occupational Health: A Personal History (presentation by

Harriet Hardy, an MD who has made herself a thorn in industry's—and the AMA's—side for many years).

- Occupational Health: How to Survive your Workplace (more concrete information provided by Urban Planning AID).
- Health Hazards to Medical Area Workers (presentation for the Harvard Medical Area workers and others, by the occupational health and safety committee of the District 65 Organizing Committee).

Here, we would like to present some general ideas and questions discussed at these workshops:

Why would the women's health movement be interested in occupational health? Because we, as health workers, take care of working women; because we are working women ourselves; and because of the special concern of the women's movement with the neglect of preventive medicine in favor of more profitable treatments. In particular:

- Women's physiology has been badly studied or not studied at all. On the one hand, male/female distinctions are made in job roles (such as restrictions on heat exposure) that are probably unscientific and discriminatory. On the other hand, risks to pregnant women (and to fathers-to-be) are very rarely taken into account.
- Plastics, electronics, and the medical industries, each employing many women, are among the fastest growing segments of the U.S. economy and may be introducing new and original toxins for their workers at an alarming rate. Although "women's work" is stereotyped as "clean" and "safe," it will may not be.
- Women are concentrated in low-paying jobs with little unionization and little control over their environment.
- Occupational disease is strategic: this is where we can locate and control toxins before the general community has been exposed. (Lead poisoning, for example, has been a known job hazard for many years, though much good it did...) Most occupational disease can be prevented, ultimately benefiting the whole community.

RAPE

A summary of most of the ideas and presentations at the Conference on the topic of rape is included in the three following contributions:

Rape Talk

Synopsis by Pauline Barr

This talk was primarily based on an analysis of 1,070 questionnaires which were returned to *Vive Magazine* by rape victims (7% of the sample were women on whom the rape was not completed), and secondarily on a report about what hospital policy should be towards rape victims, written by a group of Chicago feminists. The latter proposes volunteer rape victim advocates (so as not to be co-opted by the paying institution, volunteers working in hospital rape centers, located according to the Distribution of rape victims in the county, as well as in two special centers for child victims. The report proposes that the volunteers be laywomen rather than therapists, since the skills required are human skills—listening and supporting skills—rather than the probing and interpreting that is part of the therapeutic process. Detailed medical procedures and a special supplement on child victims are included. Congressman Abner Mikva has stated he will insert this report in the Congressional Record, so that it will be available (date unknown) to more people.

The research supported what we women all know, i.e., the seriousness of the effects of rape. About half the women suffered a loss of trust in male-female relationships; about 1/3 were affected sexually, had nightmares and had hostility toward men, about 1/4 said they felt a loss of self respect; about 16% had suicidal feelings, about 16% felt a loss of independence, and 14% had physical injuries. Only 41% of the rapists were total strangers, and the more intimately the victim knew the rapist, the more serious were the psychological effects. Almost half the attackers were calm or matter of fact, and a quarter were contemptuous, angry and righteous. (This belies the myth that rape is a crime of sexual passion). Psychiatrists sometimes say a

gas is a substitute phallus, but after analyzing these data I think the reverse is true. A phallus is a substitute gas. Rape is clearly a power trip.

There is some good news. The police have reacted more sympathetically over time, a reflection of the influence of the women's movement. Furthermore, some women reacted constructively to the rape, feeling more strongly about standing up for themselves, joining anti-rape groups and learning self-defense. Joining an anti-rape group was associated with the rapist being convicted. Women who joined women's groups were more likely to join anti-rape groups and feel more strongly about standing up for themselves. A somewhat abridged version of this research was in the June, 1975, *Viva*.

Report of Rape Working Group

by Doreen McDowell

The Rape Working Group arranged three types of workshops that were concerned with the needs of "the victim" and emphasized self (or common) help as opposed to professional—or capitalist—help. The three types of workshops were: Rape, Prostitution, and Prison Issues. We sought the common denominator in each as follows:

1. The mythology surrounding each issue.
2. Racism, sexism, and classism in the criminal justice system.
3. The dangers of professionalism in resolving each issue.
4. Health care in each issue.
5. The attitude of contempt with which the rape victim, the prostitute, and the prisoner are regarded.

Rape—

There were three different workshops which dealt with the process of understanding rape on three different levels.

The first level (or workshop) was concerned with the immediate needs of the victim which are health care and community support. One workshop was conducted on the site of the Conference on Women and Health, while the other one was actually at the Boston Area Rape Crisis Center itself. These two workshops were conducted by the Rape Crisis Center, a group of community women, many of whom are rape victims.

The second level (or workshop) dealt with information and statistics which have been accumulated by professionals as well as with the role of professionals in the health delivery system. It was pointed out that professional women have credibility in many places, while the rape victim—whose perspective and insight is most important of all—often is ignored, or worse, usurped and exploited.

This leads to our third level (or workshop) which was concerned with the causes of rape rather than the symptoms. The tapestry of racism, sexism, and classism creates the backdrop for our daily existence. One of its manifestations involves physical rape. We dealt with questions like, "Why is there rape?", "Where does it come from?", "Why do men do it to women?". There were three distinct groups represented on this panel discussion. We were scattered around the room so as not to create the typical rape model scenario, i.e., speakers in the front of the room and the passive audience in the rear. The groups were as follows: rape victims from the Boston Area Rape Crisis Center, rape victims from the Boston Bail Fund Project, and women from the Feminist Alliance Against Rape, Washington, D.C.

The Rape Crisis Center women, who act as victim advocates in court, discussed the ambiguity they felt when walking into a courtroom and seeing the power dynamic of the rape victim on one side—the rapist on the other—and the judge seated above them, deciding their fate and receiving prestige and a salary from it. The R.C.C. workers found it difficult to deal with the court system which reproduces the Rape Model: the judge as ruling class has control over the rape victim and the rapist who are dependent on the professionals—the lawyers and psychiatrists—to convey their position. What evolves is a contrast between professionals who feel completely detached from the two people involved. It is clear that the immediate and total support of the R.C.C. workers went to the rape victim. However, we do not want to provide another

convenient excuse for upper-class identified people (like the judge and other professionals) to exploit lower-class people. This situation is compounded by our knowledge that upper-class men, who also have access to other kinds of power besides physical rape, can act out their normal conditioning of dominance and control without fear of ending up in court. In the rare instances when they are prosecuted for rape, their crime usually is not called rape.

Women from the Bail Fund read a statement saying that "rape is an archetype of socially acceptable behavior between the classes, the races, and the sexes." Women from the Fund felt comfortable with the fact that one of their most recent cases involved a lower-class man who was arrested for rape. While we do not tolerate physical abuse of women, we do not wish to provide the criminal justice system with another person, especially someone who is already exploited, to process through its factory.

This led to our third set of panelists, the Feminist Alliance Against Rape, who are allied with women working with P.A.R. (Prisoners Against Rape) a group of men in Lorion prison and of women working in anti-rape projects. These prisoners all admit to having raped and are politicized about their role in the rape issue. They see how rape serves the interests of objectifying and controlling women and they also use the study of rape as a model for understanding the issues of oppressed peoples. The idea behind "Prisoners Against Rape" was provide an alternative approach to dealing with the rape issue. Rather than devoting our time and energy to what we jokingly refer to as the "protection racket"—that is, getting more protection from police, slight changes in legislation and harsher sentences for rapists, we could be working with the rapists themselves. Supporting politicians who, on the one hand, make a small change in rape legislation, and on the other, cut rest control, perpetuates the cultural conditions that foster rape. The concept of P.A.R.—rapists and victims in the same group, studying the rape dynamic—is the most positive force to emerge from the anti-rape movement since W.A.R. (Women Against Rape). What we observe is upper class identified men and women standing in judgment of a physical rape and creating an entire industry with a production line of "protection", "counseling", and "correction" of the "crime". And so, for the rape victims and the rapists to stand up and announce that we can be allies in a struggle is a very exciting and politically threatening idea.

Prostitution—

To most women graduates of the sexual liberation movement of the '60's, prostitution is merely the skill of making a long story short. Prostitution is still a closet issue in the movement, but, in it is the archetype of all that is unfair and oppressive to women in the life, we determined that legalization of the work is no solution, since it would allow for legal rather than illegal exploitation of women. Rather, decriminalization is a more interesting goal. In terms of public health issues, it is a myth that venereal disease stems from prostitutes (less than 5%). This myth, of course, once again puts the responsibility for VD back entirely onto women—as opposed to requiring that men share the responsibility. If the responsibility involves a monthly inspection, then men should be inspected, too. If men wish to set up regulatory agencies, ripe for graft and corruption, let them do it with their bodies, not ours!

To work out the physical dangers concomitant with prostitution, more women supportive to each other—working together—might be a good approach. If, for example, the Johns (client) tries to violate the terms of the contract—then other women would come to the prostitute's support. In this way a prostitute might be less vulnerable to exploitive men surrounding her—the johns, the pimp, the police, the judge, lawyer, bailiff.

Health care for the hooker is an issue. Currently, she is ineligible for insurance. Also a self-help, self-examination group would be useful, since women in the group could support each other in her demands.

The guest speaker for this workshop, a woman in the life, (a prostitute), was sought in order to represent the perspective of all

prostitutes. This was, at best, a naive patsy, since she could not speak for all prostitutes anymore than the movement itself has one single spokeswoman. Class differences create different problems and without sensitivity to this, the prostitution issue is deadlocked.

Women in Prison—

Health care services for women in prison are bad. Nutrition awareness is non-existent. There is no physical exercise, except for certain very physically demanding work that some of the prisoners must do. Other kinds of jobs consist of sitting around without any exercise and doing things like sewing the American flag or working on oxidized key punch equipment. Most women in prison are mothers, and those without husbands or relatives stand a chance of losing their children to the state. The way the prison responds to the tremendous frustration brought on by this lifestyle is to drug the women in order to eliminate their threat. Mental, physical, and economic deprivation serve to perpetuate a lifestyle that makes these women targets for exploitation in or out of prison.

Conclusion:

Our working group was concerned with victim issues—rape, prostitution, and prison. Our emphasis was self-help, our aim—control of our bodies and our lives.

Professionalism

by Deb Friedman

(reprinted with permission from the *Feminist Alliance Against Rape Newsletter*, Fall, 1975)

Feminists working in anti-rape projects generally welcome the increased involvement of professionals in the issue of rape. From the time that rape crisis centers were first started, feminists have called attention to the need for professional involvement in gaining better services and more sensitive treatment for rape victims. Professional women have also been involved as members of centers run by feminists and have contributed valuable skills to these projects.

As more and more professionals are becoming involved in anti-rape work, however, there is an increasing tendency to defer to professional leadership in anti-rape projects. While professional skills and knowledge are valuable resources in a project, there is no valid reason for professionals to control rather than work as peers within the rape issue.

The need toward professionalism in rape is the result of a general bias in favor of professionals in this society. That is, we are taught to believe that anyone who has gone to school and gotten a degree is better qualified to decide how to deal with a problem than someone who has educated herself, and been educated by other women, on a particular issue.

Rape Crisis Centers were developed originally by feminists as structures through which women can begin to take back control over our lives—control which is denied in part by the threat of rape. Those women saw that by joining together to protect ourselves against rape, and by helping each other deal with rapes that occur, we can become stronger and better able to control what happens to us.

In their manual, "How to Organize a Women's Crisis Service Center," women of the Ann Arbor Women's Crisis Center explain the "self-help" basis of feminist organizing:

"The very basis of the center stems from the concept of 'self-help.' By 'self-help' we mean getting away from traditional therapy. At the heart of traditional therapy is the idea of a person with troubles going to someone more skilled and submitting herself to that person. In place of this approach, we have a philosophy of peer counseling. This means that one does not depend upon another to make one's own decision. A person has to decide, for herself, the best way to deal with her problems. The counselor is there to listen to a woman and then to reflect her feelings back to her. We think that once a woman can deal with her feelings openly and honestly, she is better able to help herself. And self-help also means that we learn by helping others. All of us

are equal—no one has authority over another. Each woman at the center learns to work on her own initiative and to take charge when something needs to be done.

We extend this philosophy of self-help to the women who call us. For example, when a woman tells us she wants an abortion, we talk with her and refer her to a good place—but she makes all the necessary phone calls and arrangements. The counselor's role is merely that of a back-up person, to help out if problems arise in making the arrangements. We want to help women to help themselves!"

Social workers, psychologists and counselors who assist rape victims as part of their jobs, often do not identify with the politics of self-help. They regard peer counseling as little more than a mental health technique and assume that non-professional "peer counselors" must be trained and supervised by mental health professionals, even though many of these professionals are uneducated about rape and are often unable to relate to rape victims from varying backgrounds and experiences. Unfortunately, this assumption is often shared by non-professionals themselves.

Women in mental health jobs are also encouraged to deal with rape as an individual woman's problem, rather than a political issue. Their job is to help rape victims recover from the emotional trauma, and adjust to a society in which further rapes are still a distinct possibility. Even though they see that the victim's difficulties are the result of a social problem, many mental health professionals don't assume any responsibility for finding solutions to the problem. Like other professionals, they are taught to focus on only those aspects of a problem that fall within their specialization. An anti-rape project which deals with rape politically will be working on all aspects of rape. Each area of specialization within the project will be related through a common strategy, so that more than one aspect of the problem can be confronted at the same time.

Current studies on rape (e.g., Queen's Bench Foundation's Rape Victimization Study) quote professionals who state that women are usually permanently scarred by the experience of being raped. This is in keeping with traditional female psychology which views women as emotionally weak and unable to withstand stress. But it is in contrast to the experience of rape hotline staffers who have observed that most women are strong enough to cope with the trauma of rape. A woman who has never been able to tell anyone about her rape will probably have some on-going problems, particularly when her feelings are reinforced by poor attitudes in society. But a woman who gets emotional support from her peers usually won't continue to have problems. Because of rape crisis centers, many victims have been able to receive the emotional support they need from other women to deal with rape.

Professionals readily acknowledge their indebtedness to feminists for calling attention to the problem of rape. However, they fail to understand that feminists themselves recognized the problem of rape only after seeing, in political terms, how rape enables men to have power over women. Feminists saw that their oppression as women stemmed in part from the ability of men to terrorize and intimidate them, and thus recognized the need to organize with other women to eliminate the source of men's unequal power. Professionals often seem not to feel a need to relate to political activism outside of the institutional structures. The pressure which forced institutions to begin to deal with rape in the first place developed out of the political activities of feminists. There is no reason to believe that further change will come from within those institutions, or from professionals who are accountable only to the institutions.

There are often many excuses given for professionals who ignore community women dealing with rape. Usually the project involved is a rape crisis center which, due to lack of resources, is unable to provide as comprehensive and as dependable a service as an institution. Rather than make their skills accessible to these groups, or find ways of providing resources to these groups, many professionals start their own projects with funding that they are able to obtain because of their professional status. Many community-based, feminist groups have been asked for free

advice by these professionals. Thus, when it comes to gaining information, skills, etc., professionals are often willing to consider non-professionals working in the issue to be their peers. However, when it comes to determining who should receive the funds in a particular community, or who has credibility, professionals are given automatic preference.

Basically, we feel it is necessary to examine many of the premises upon which professionalism rests, not just within anti-rapе organizing, but in terms of the general implications of professionalism in our society. We do this not with the intention of disparaging individual professionals, many of whom are a progressive element within their various fields.

We feel that professionalism is a means of maintaining class distinctions in this society. Professional degrees are not readily obtainable by all members of society, nor are they necessarily accessible to the most capable individuals. Instead, educational opportunities and encouragement are provided primarily to the middle class. While some aggressive individuals from working or lower class backgrounds have been able to become professionals, members of these classes have much less expectation of gaining professional careers than middle class individuals.

Meanwhile, there are no structures through which professionals (and non-professionals) can be accountable to their communities. In the absence of structures, accountability comes through individual conscience. Instead, professionals are encouraged to be accountable mainly to their professions and to the institutions which employ them. This encouragement is present in the form of professional associations, status which is bestowed upon the professions, and the mystification of professional knowledge. Certainly professional skills are needed to do specific jobs, but having skills does not automatically qualify one to make decisions regarding where or how those skills should be applied. These are decisions which society as a whole should make; and people whose lives are affected by those decisions should have a major say in making them.

*p. 81. Manual available from the Women's Crisis Center, 306 N. Division St., Ann Arbor, Michigan, 48108.

by Deb Friedman

REPORT OF THE LESBIAN WORKING GROUP

The Lesbian working group began its plans for workshops at the Conference on Women and Health with several goals. These included: 1) making a strong Lesbian presence at the Conference known in order to continue the struggle against heterosexism both within the medical establishment and the women's health movement; 2) providing workshop time and space for Lesbians interested in health work to define our health issues, and to break down our isolation from one another; and 3) to begin work on a much needed pamphlet about Lesbian Health issues, written by Lesbians from a Lesbian perspective. Both the working process and the results at the Conference were incredibly successful.

The working group consisted of Lesbians involved in some aspect of health work or the Lesbian-feminist movement. Decisions and work allocations were made collectively by the group. We were a remarkably compatible group; everyone involved took about equal responsibility and initiative in proceeding with Conference plans, avoiding the all too common phenomenon of one or two women really doing all the work. We were also personally compatible so that the work process was enjoyable as well as productive.

The workshops we planned were based on a pyramid shaped structure. We wanted to begin by basing the workshops in a large panel discussion for a general audience, proceeding to a smaller group discussion about particular issues raised by the panel, and closing with small special topic workshops for Lesbians only so that we might also have a chance to share information and experiences among ourselves.

The first workshop was titled "Lesbians and the Health Care System" and its purpose was two-fold: to introduce many of the issues Lesbians face in working and giving health care; and to serve as consciousness raising for the Conference body as a whole about Lesbians and health care and Lesbianism in general. The panel discussion, attended by about 150 women, included the following topics:

1. The Lesbian as health worker: class differences in the

Photograph by Vicki Laurence



medical system, i.e. doctors, nurses and other health workers; responses of staff and patients especially regarding the Lesbian's credibility as a "well" person: i.e. responsible and adult; dealing with staff response to other Gay people including stereotyping, jokes and isolation.

2. Mental health and therapy; a look at how therapists and mental health workers have dealt with, acknowledged or ignored Lesbianism as a sexual lifestyle and choice.

3. The gynecological experience including assumptions of heterosexuality and assumptions and stereotypes about Lesbians.

4. The hospitalization experience; problems with visitation rights and isolation.

5. Lesbian motherhood.

The second level of the workshop structure was a series of four small (40 person) workshops with the purpose of defining the panel issues in more detail. It was hoped that these workshops would begin to bring women together around the areas of concern so that possible action plans or solutions could be formulated. The four topics discussed were: 1) The Lesbian as Health Worker; 2) Mental Health and Therapy; 3) The Hospitalization Experience (Lesbian as patient) and the GYN experience; and 4) Lesbian motherhood. All of these workshops were well attended and will be reviewed.

The top level of the workshop pyramid were those that the working group had geared towards Lesbian women. The purpose of these workshops was to define how we, as Lesbians, define our own health issues and what we want to see done for our own health care. The room allocation was for workshops of 25 women; in fact attendance ranged from 25 to 86. Several workshops split into several sections so that the format of small group discussions, brainstorming, testimony, etc., could be maintained. The workshop topics were:

1) Lesbian as Health Worker: a chance to share experiences and solutions about problems of sexism and heterosexism experienced by Lesbians at all levels of health care delivery.

2) Lesbians working in the Women's Health Movement: a discussion documenting the fact that feminist health care is not free of heterosexism and heterosexist assumptions. Lots of shared experiences and some possible solutions proposed.

3) Artificial Insemination and Maternity: dealing with questions such as: How do we relate to bearing children? How can we become pregnant without social relations with men? What about childbirth and child-rearing?

4) Infections and Sexuality. What types of sexually transmitted infections do Lesbians get? What can we learn about infections and their transmission? What do we know from our own experience?

5) Lesbian Related Research: Who knows of any? Where should Lesbian related research be done? By whom? For what use? How do we do our own research?

6) Sex and Sensuality: How do we define ourselves sexually? What does it mean to be a woman-loving-woman? What parts of our sexuality are our own? What parts are remnants from a patriarchal, heterosexual culture? How do we develop a woman-identified sexuality?

The final Lesbian workshops reflected both the action orientation of the working group and the wish to remedy the almost total lack of Lesbian-written Lesbian-related health materials. Titled "Lesbian Pamphlet Workshop" this small meeting was held with the express purpose of beginning to hammer out the format, content and method for writing a health pamphlet by and about Lesbians. Mailing lists were compiled and workshop notes (each facilitator had requested a scribe at all previous workshops) were collected. The Boston area women agreed to coordinate the efforts towards a pamphlet.

Since that time there have been several small meetings held in Boston. Current plans for the pamphlet include out-reach to Lesbians, health groups and women's publications across the country to solicit articles, support, news, and of course money to cover costs. The work plan will be small working groups taking responsibility for individual chapters on topics that interest them. The coordination and overall maintenance will be done

through a Boston-based work group. The Lesbian Pamphlet Writing Group has begun a tentative, non-inclusive list of chapter topics for the pamphlet which include: Sexuality, Lesbian Related Research, Mental Health, the Well Woman, Sexually Transmitted Infections; Lesbian Motherhood etc. We are hoping that women other than in the Boston area will choose these or other topics and take responsibility for writing chapters.

Questions, suggestions, information, ideas, donations etc. can be sent to the pamphlet group at:

LESBIAN PAMPHLET WRITING GROUP
c/o Women's Community Health Center
137 Hampshire Street
Cambridge, Ma. 02139
(617) 547-2302
att: Auth-Steve

THE SECOND FORTY YEARS

by Sally H. East

As the planning for the conference proceeded, specific age and interest groups emerged as having special problems as they related to health. Adolescents and lesbians, for example, were acknowledged as special groups. It became imperative to some members of the planning committee that "older" women ought to have the opportunity to meet in workshops.

There was an effort to avoid the words "middle aged", "elderly" and "older" since each of these terms, and others like them, carried a stereotype of attitude which many women felt to be pejorative. A general descriptive phrase—"The Second Forty Years"—was agreed upon, and six workshops were planned under that rubric.

The initial workshops, called "The Second Forty Years", was the best attended. Marjory Collins, the editor of *Prime Time*, a feminist journal for "the liberation of women in the prime of life", was present to comment on the film on menopause. The atmosphere, generally, was one of excitement and had the quality of a "speak out". Many women were eager to share their experiences of menopause, and also attitudes regarding sexuality, the internalization of prejudice against women as they age, and problems related to employment, relationships, and, most specifically, the attitudes of male gynecologists toward "female complaints". What emerged most clearly was the realization that women in this age group have a strong need for discussions related to a full range of problems.

There were five other related workshops: "Menopause", with findings presented by members of the Boston Women's Health Book Collective, based on the research they had done for the second edition of *Our Bodies, Ourselves*; "Womans wisdom: Learning from Older Women"; "Older Women and Sexuality"; "Aging"; and "Nursing Homes".

Space does not permit a full discussion of each of the workshops, but one, because of what occurred, ought to be noted. "Womans wisdom" was planned to be an opportunity for women working in the health field to hear from two women who occupied positions of responsibility and authority, in, respectively, a large Boston hospital and a community health center. Many women attended, a large proportion of whom were relatively young and beginning their careers.

The two women spoke of their experiences surviving and succeeding in the health field hierarchy. As they spoke, the temperature, both literally and emotionally, began to rise, and all the signs of angry confrontation began to emerge. The women in the group expressed outrage that the two women speakers not only described their experiences but appeared to accept the conditions under which they had been forced to operate: rampant sexist attitudes, acceptance of secondary positions when qualifications and experience indicated higher level jobs, the need to "win over" bosses, inferior salaries, etc. The two women speakers were distressed at the attitude of their audience, and generally adopted an attitude of "that's the way things are and you'd better accept them if you want to survive". The moderator

made considerable effort to bring the two opposing attitudes to, at least, acknowledge the point of view of the other. One thing became clear: the older women had clear insights into the categorical non-acceptance of their point of view and learned what the women's movement in health care felt about the current status of women in health care institutions and why there was the move to establish alternative institutions. The women in the workshop learned, first hand, that attitudes they considered to be anti-feminist were shared by women they had imagined to be their allies. It was a most successful workshop, where much was

learned, largely because of its confrontational nature.

This reporter would strongly urge that "Women in the Second Forty Years" be included in all future women and health conferences. The population in the United States is gradually becoming older and every woman, sooner or later, will have to resolve for herself the problems which are part of that phase of her life. It is hoped that these workshops will help women to prepare themselves for this time, or resolve the difficulties they are already experiencing.

RESOURCES SECTION

BIRTH CONTROL, ABORTION, AND STERILIZATION

Abortion Counseling Service of Minnesota. *Abortion/A Guide for Teachers*. 1974. For junior high school and up. Available from the Service, 549 Toropike Rd., Golden Valley, MN 55416 (\$1.25).

Association for Voluntary Sterilization, Inc. 14 W. 40th St., NY, NY 10018. Provides information on sterilization, speakers, referrals to doctors all over the country.

Bellings, John. *Natural Family Planning*. Collegeville, MN: Liturgical Press, 1975 (rev.). Handbook which includes charts and stamps for recording mucus observations. Available from FWHC, 1112 Cresshaw Blvd., LA, CA 90019 (\$2.25 plus postage and handling).

Blackwell Women's Health Resource Center, 203 West Holly, Bellingham, Washington 98225, 206-734-3592. This group teaches the mucus method on a regular basis without the Catholic orientation. They may be contacted for information on their experiences and possibly to conduct workshops.

Bremner, William, and David deKretser. "Contraceptives for Males." *Signs: Journal of Women in Culture and Society*. 1: 387-396, 1975.

Brown, Lester E., & Kathleen Newland. *Abortion Liberalization: A Worldwide Trend*. Available from Worldwatch Institute, 1776 Mass. Ave. NW, Washington, D.C. 20036

Carens, E. "Sterilization: Women Fit to Be Tied." *HealthAPAC Bull.* 62: 1-6, Jan/Feb '75.

Center for Disease Control. *Abortion Surveillance Report*. Annual Summary of U.S. 1974 Data by State. Characteristics of women getting abortions, mortality and morbidity. Available from CDC, Family Planning Evaluation Division, Abortion Mortality, Atlanta, GA 30333.

Cohen, Marshall, et al., eds. *The Rights and Wrongs of Abortion*. Princeton, N.H.: Princeton University Press, 1974.

Emory-Grady Family Planning Program. *The Joy of Birth Control*, by Stephanie Mills, magazine format, written especially for teenagers. *The View from Our Side*, written by and for men. *Contraceptive Technology 1975-8*; useful information though somewhat outdated. Available from the Program, Box 28069, Grady Memorial Hospital, 80 Butler St., SE, Atlanta, GA 30303 (\$1.00 each plus postage).

Family Planning Perspectives. Bi-monthly publication of Planned Parenthood Federation of America. Includes up-to-date medical and sociological information of family planning; not skeptical enough of the PPI and the IUD. \$15/yr.

Family Planning/Population Reports. Publication of Alan Guttmacher Institute, 515 Madison Ave., NY, NY 10022 (\$20/yr. individual; \$15/yr. institution).

Feminist Women's Health Center. *Abortion in a Clinic Setting*. Available from FWHC, 1112 Cresshaw Blvd., LA, CA 90019 (\$3.00). Excellent resource. Also, contact FWHC about their new Birth Control Subscription Program, which offers a women-controlled setting in which to explore alternative birth control methods.

Fleishman, Norman, and Peter Dixon. *Vasectomy: Sex and Parenthood*. Garden City, NY: Doubleday and Co., 1973.

Gray, Marian and Roger. *How to Take the Worry Out of Being Close*. Includes lively descriptions of birth control methods, abortion, venereal disease, and infections. Available from M. Gray, Box 2822, Oakland, CA 94618 (rev. ed. should be about 75 cents).

Hardin, Garrett. *Mandatory Motherhood*. Boston: Beacon Press, 1974. Argues against the right-to-life groups.

Health Research Group. "Report on the Morning-After Pill." Dec. '72. Available from HRG, 2000 P St., NW, Wash, DC 20036 (25 cents).

HealthRight, Inc. Pamphlets on vacuum aspiration abortion and saline abortion. Order from HR, 175 Fifth Ave., NY, NY, 10003 (35 cents each). See also Spring '76 issue of *Health Right* for good article on sterilization (world-wide reports).

Herman, Judith, MD. "Forced Sterilization." *Sister Courage* Jan '76 (Box 296, Allston, MA 02134). Send 50 cents.

International Reference Center for Abortion Research. *Abortion Research Notes*. A guide to publications throughout the world on the subject of abortion. For subscription info, contact IRCAR, 8307 Whitman Dr., Bethesda, MD 20804.

Lacey, Louise. *Lacareption—A Feminine Gateway into Fertility and Contraception*. NY: Coward, McCann and Goughigan, 1975.

Lader, Lawrence. *Abortion II: Making the Revolution*. Boston: Beacon Press, 1973.

Lader, Lawrence, ed. *Fooding Birth Control—Male and Female Sterilization*. Boston: Beacon Press, 1972.

Lane, Margaret, et al. "Successful Use of the Diaphragm and Jelly by a Young Population: Report of a Clinic Study." *Family Planning Perspectives*, Vol. 8 #2, March-Apr '76. Good study indicating 98% effectiveness rate with diaphragm.

Lieberman, E.J. and E. Peck. *Sex and Birth Control: A Guide for the Young*. NY: Schocken Books, 1973.

Nancy Goat Productions. *Abortion Evr* (comic book). Available from N.G.P., Box 845, Laguna Beach, CA 92652 (65 cents). Good discussion of abortion particularly for those who wouldn't read a book or article. Useful for many teenagers.

NARAL (National Abortion Rights Action League). A pro-choice organization which publishes a newsletter with up-to-date coverage and suggestions for action. Following literature is available from NARAL, 250 W. 57th St., NY, NY 10019. *Abortion Law Reporter* (\$25.00/yr. individual subscription; \$45.00/yr. for institutions). Includes case summaries, glossary of legal terms, explanation of state and federal court decisions, and a NARAL report. *Abortion Rights Action Bulletin* (Single copy free; 2-49 copies 6 cents each); *Outline* for getting involved in political action and publicity for abortion rights. *Abortion: Safe or Dangerous?* Single copy free, 100 for \$6.00; *Contrain* legal and safe abortion with illegal, dangerous procedures. *The Right to Choose: Facts on Abortion* (Single copy free); *Good summary of legislation, litigation, public opinion, and health and social impact* (ZPG publication).

The Natural Family Planning Association of Connecticut, Box 250, New Haven, CT 06502. Offers literature, including booklet on sympto-thermic method.

New York City Health and Hospitals Corporation, New Guidelines on sterilization for NYC, including provisions for informed consent. Copies available from HealthRight (25 cents).

Obel, W. J. et al. "Polyethylene Intrauterine Contraceptive Device: Endometrial Changes Following Long-Term Use." *J Amer Med Assoc* 212: 765-768, May '70.

Ottensder, Sheila, and Lynn Schroeder. *Natural Birth Control* NY: Bantam Books, 1977.

Prevention Magazine. "The Case Against the Pill." Good summary of the studies documenting the various hazards and side effects of the Pill.

Ratner, Herbert. "Medical Hazards of the Birth Control Pill." Available from *Child and Family Reprint Dept.*, Box 508, Oak Park, 60663 (\$1.00).

Rosenblum, Art and Jackson, Leah. *The Natural Birth Control Book*. Boston: Tao Publications, 1976. Available from: Aquarian Research Foundation, 5620 Morton St., Phila., Pa. \$3. p.p. Schaller, Diane, and Florence Kennedy. *Abortion Rap*. New York: McGraw-Hill, 1971.

Seaman, Barbara. *The Doctors' Case Against the Pill*. NY: Peter Wyden, 1969.

Shupe, J. "The Birth Controllers." *Health/PAC Bulletin*, Apr. '72.

Tietze, Christopher. *Abortion Fact Book*. Available free from The Population Council, 245 Park Ave., NY, NY 10017. Overview of current international data on abortion; legal status, incidence, complications, mortality.

Women's Community Health Center, 137 Hampshire St., Cambridge, MA 02139. Birth Control Research Project. Information is being sought from women who have had side effects, complications, or any type of unexpected reaction to conventional birth control methods. Data on other types of birth control is also welcome.

Tietze, Christopher. *Induced Abortion: A Factbook*.

Wulfsberg, A.J., and P.E. Wulfsberg. "The Food and Drug Administration and the Pill." *Social Policy*, Sept/Oct '70, p. 52-55.

Women's Research Action Project. *The Abortion Business: a report on free-standing abortion clinics*. Available from WRAP, Box 119, Porter Square Station, Cambridge, MA 02140 (\$3.50). Good discussions of patient care, workers' conditions, structures for accountability and the economics of abortion clinics.

Zero Population Growth (ZPG). *15 Facts You Should Know About Abortion and other publications*. Available from ZPG, 1346 Conn. Ave., NW, Wash., D.C. 20036 (single copy free). Also available from NARAL.

Zimmerman, Margot. *Abortion Law and Practice*. Available from Population Information Program, George Washington University, 2001 S. St., NW, Wash., DC 20009. Report on world-wide abortion laws.

FILMS

*Indicates shown at the Conference; other additions include new films we've seen and recommend.

**Abortion*. 30 min./BW. Women's Film Coop, 200 North Main St., Northampton, MA. Rental, \$20. Abortion experiences.

**Abortion and the Law*. 54 min./BW. Carousel Films, 1501 Broadway, New York, NY 10036. Apply. CBS-produced discussion pro and con abortion.

**It Happens to Us*. 30 min./C. New Day Films, Box 315, Franklin Lakes, NJ 07417. \$30. Women discuss abortion—pregnatorialization.

**Lovely's Nuclear War*. Green Mountain Post Films, Box 177, Montague, MA 01351. Color. 60 min. Rental: \$50. An excellent film about the dangers of nuclear plants.

**Taking Our Bodies Back*. 33 min./C. Cambridge Doc. Films, P.O. Box 385, Cambridge, MA 02139. \$39. Documents the women's health movement.

**Self Health*. 23 min./C. Serious Business Co., 1609 Jaynes St., Berkeley, CA 94702. \$40. Self-exam, pelvic and breast exam in context of women's group.

**A New Image of Myself*. 29 min./C. Feminist Women's Health Ctr., 1112 Crenshaw Blvd., Los Angeles, CA 90019. Apply. Beginning look at self-examination.

**Div for a Small Planet*. 28 min./C. Bullfrog Films, Inc., Box 114, Millard, PA 18935. \$30. Based on Lappe book.

**Nutrition in Pregnancy*. Hathaway Productions, 4349 Topanga Ave., North Hollywood, CA 91604. Apply.

**Eat, Drink and Be Wary*. 20 min./C. Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA 90069. \$21. What's wrong with the food we eat.

**Period Piece*. 10 min./C. Emily Calpepper, 801 Somerville Ave., Somerville, MA 02143. \$25. A menstrual diary and self-exam while menstruating.

**Linda's Film*. 18 min./C. Phoenix, 470 Park Ave. 5., New York NY 10016. \$30. A young woman gets her first period and has to explain it to a male friend.

**Rape Culture*. 35 min./C. Cambridge Doc. Films, P.O. Box 385, Cambridge, MA 02139. \$40. Examines popular media and expands the definition of rape and its myths.

**Not a Pretty Picture*. 83 min./C. Martha Coolidge, 236 East 19th St., New York, NY 10003. Apply. Dramatic story of a date rape in prep school—actors discuss feelings.

**Home Born Baby*. 47 min./BW. Insight Exchange, P.O. Box 42584, San Francisco, CA 94106. \$60. A joyous home birth, midwife and doctor assisted.

**Nature's Way*. 20 min./C. Appalshop, Box 743, Whitesburg, KY 40858. \$25. Midwife sequence—mountain healing traditions.

**Moons and Swims*. 20 min./C. Boston Assoc. for Childbirth Ed., 237 North Ave., Weston, MA 02153. \$8. A traditional pregnancy and childbirth experience.

**Talking About Breast Feeding*. 17 min./C. Polymorph Films, 331 Newbury St., Boston, MA 02115. \$20. About breast feeding supported by La Leche League.

**Child Care*. 20 min./BW. Third World Newsreel, 26 West 20th St., New York, NY 10001. \$20. Community works together for child care centers.

**Leavenie*. 1916 min./BW. Nat'l. Film Board of Canada, 1251 Ave. of the Americas, New York, NY 10020. \$12. A single parent dealing with post divorce adjustment.

**About Sex*. 23 min./C. Texture, 1600 Broadway, New York, NY 10019. \$25. Women and men teenagers discuss sex.

**Missie Movie*. 12 min./BW. Feminist Women's Health Ctr., 1112 Crenshaw Blvd., Los Angeles, CA 90019. \$25. Growing up as a lesbian.

**Marxist Doctors in Rural China*. 52 min./C. Cambridge Doc. Films, P.O. Box 385, Cambridge, MA 02139. \$75. Extensive footage of People's Republic paramedic system.

**Do No Harm*. 42 min./C. Odson, 1619 Broadway, New York, NY 10019. \$50. A study of abuses of drug industry.

**I Am Somebody*. 28 min./C. McGraw Hill/Contemporary, 1221 Ave. of the Americas, New York, NY 10020. \$30. Striking women hospital workers in the South.

**Janie's Janie*. 25 min./BW. Odson, 1619 Broadway, New York, NY 10019. \$25. Welfare mother takes control over her life.

**Women on the March*. 58 min./BW. McGraw Hill/Contemporary, 1221 Ave. of the Americas, New York, NY 10020. \$28. Historical treatment of suffrage.

**Hospital*. 84 min./BW. Ziporah Films, 54 Lewis Wharf, Boston, MA 02110. Apply. Fred Wiseman looks at Metropolitan Hospital in New York.

- **Lucifer Hospital*. 15 min./BW. Third World Newsreel, 26 West 20th St., New York, NY 10011. \$25. Community tries to make Bronx Hospital responsive.
- **Margaret Janger*. 15 min./BW. McGraw Hill/Contemporary, 1221 Ave. of the Americas, New York, NY 10020. \$12. Historical documentary.
- **Miss America*. 7 min./BW. Third World Newsreel, 26 West 20th St., New York, NY 10011. Apply. Spoof of Miss America.
- **Make Out*. 5 min./BW. Third World Newsreel, 26 West 20th St., New York, NY 10011. \$15. Satirical view of seduction of young woman in car—serious implications.
- **A Woman's Film*. 40 min./BW. Third World Newsreel, 26 West 20th St., New York, NY 10011. Apply. Women talk about their awakening consciousness.
- **Virginia Woolf*. 10 min./C. ACI Films, 35 West 45th St., New York, NY 10036. \$15. Dramatization of the life and work of Virginia Woolf.
- **Anonimo*. 58 min./C. Phoenix, 470 Park Ave. S., New York, NY 10016. \$75. Story of a woman conductor.
- **Lucia*. 140 min./C. Tricontinental Films, 333 Sixth Ave., New York, NY 10014. Apply. Three epics of Cuban womanhood.
- **Blood of the Condor*. 85 min./BW. Tricontinental Films, 333 Sixth Ave., New York, NY 10014. Apply. Bolivian Indian women—victims of U.S. population control program and sterilization; Indians seek revenge.
- **Salt of the Earth*. 90 min./BW. Monday & Collins, 270 Willow St., San Jose, CA 95150. Apply. New Mexico miners strike and women break through sexism to move toward solidarity.

Films of Interest—In Production

- The Maternity Center Film* (working title). 45 min./BW. Haymarket/Kartemquin, 1901 West Wellington, Chicago, IL 60659. Avail. Fall '76. People fight against a larger hospital complex to save a maternity center in Chicago.
- Health Care from Our End of the Spectrum*. 25 min./C. approx. Women Make Movies, 257 W. 19th St., New York, NY 10011. Summer '76. A look at three women-oriented clinics and a history of women as healers.
- Cervix Conis*. 5 min./C. animation. Women Make Movies, 257 W. 19th St., New York, NY 10011. '76. A true life event from the Carol Downer trial—"The Great Yogurt Conspiracy."
- The Politics of Nursing* (working title). 30 min./C. approx. Joan Fluck, 7 Holly Ave., Cambridge, MA 02138. Spring '77. The history of nursing and women as healers—a detailed assessment of current situation—conflicts, politics and changing roles.

Video

- Self-Help Clinic*. 30 min./BW. Feminist Women's Health Center, 1112 Crenshaw Blvd., Los Angeles, CA 90019. Apply.
- Women Controlled Abortion*. 30 min./BW. Feminist Women's Health Center, 1112 Crenshaw Blvd., Los Angeles, CA 90019. Apply.
- Menstrual Extraction*. 40 min./BW. Feminist Women's Health Center, 1112 Crenshaw Blvd., Los Angeles, CA 90019. Apply.
- Radical Mastectomy*. 30 min./BW. Feminist Women's Health Center, 1112 Crenshaw Blvd., Los Angeles, CA 90019. Apply. Content of all is fine and informative, but technical quality of tapes is poor.
- Miss Being Born*. 25 min./BW. Birthday, P.O. Box 338, Cambridge, MA 02138. \$15. Beautiful tape of woman giving birth herself, surrounded by family and friends.

Audio

- Tape of 75 Women & Health Conference*. 30 min. Feminist Radio Network, P.O. Box 5537, Washington, D.C. 20016.

Slide

- Image of Nursing*. 50 min. Lexington Nurses NOW, P.O. Box 651, Lexington, MA 02173. \$15. Explores stereotypes of nurses.

Occupational Health & Safety. 25 min. Urban Planning Aid, 639 Massachusetts Ave., Cambridge, MA 02139. \$5. Beginning film on job-related health issues; good for worker training and union meetings.

**American Health Empire*. 50 min. Amer. Friends Service Comm., 104 Jonas St., Cambridge, MA 02139. Apply. Exploration of profit motive of American health industry.

The Yeasty Yini—Rustin GYN Exam. L.I. NOW, P.O. Box 68, Bank Plaza Station, Merrick, NY. \$35. We haven't seen it, but heard it was good.

Gay People/Straight Health Care (filmstrip). 15 min. Gay Nurses Alliance, P.O. Box 5687, Philadelphia, PA 19129. Apply. Dramatization of gay nurse and gay patient experiences.

We wish to thank the following groups and individuals for their assistance in programming and for the donation of their films or slides.

Marcia Zalowitz and the Boston Public Library Film Dept.
American Friends Service Committee
Boston Area Childbirth Education
Cambridge Documentary Films
Diane U Productions
La Leche League
Lighthouse Films
The Los Angeles Feminist Women's Health Center.

LESBIAN HEALTH

Gay Community Services Center. "Gay VD: Facts for Women and Men." Available from the Center, 1614 Wilshire Blvd., LA, CA 90017 (8.20).

Gay Public Health Workers (a caucus of the American Public Health Assoc.) Currently working on a variety of problems encountered by gay persons in receiving and providing health care. Projects include: Alcoholism/Drug Abuse Clearinghouse, c/o Gay Community Services Center, Box 27209 (working on a list of alcoholism and drug abuse centers offering special services to gay men and women) and VD Clearinghouse, c/o Gay Community Services Center, Box 28777, 1213 N. Highland Ave., Hollywood, CA 90038 (working on a manual for organizing gay VD clinics and testing facilities developing a complete manual on gay VD and other gay-related health problems). If interested in joining the Gay Public Health Workers caucus or receiving their newsletter, write to the caucus, at 206 N. 35th St., Phil., PA 19104.

Horstein, Frances. *Lesbian Health Care Packet*. Available from FWHC, 1112 Crenshaw Blvd., LA, CA 90019 (\$2.00).

Lesbian Health Care Pamphlet Writing Group. Currently working on a health pamphlet for lesbians—contributions welcomed. Write c/o Women's Community Health Center, 137 Hampshire St., Cambridge, MA 02139, for more information.

Lesbian Research Collective. See "Women and Mental Health."

MENOPAUSE AND THE SECOND FORTY YEARS

Bart, Pauline. "Why Women's Status Changes in Middle Age: The Turns of the Social Ferris Wheel." Available from the author, Abraham Lincoln School of Medicine, Division of Sociology, Univ. of Illinois, Box 6998, Champaign, IL 61820.

Bart, Pauline. "Depression in Middle-Aged Women." In *Woman in Sexist Society: Studies in Power and Powerlessness*, V. Gornick and B.K. Moran, Eds., NY: Basic Books, 1971, pp. 99-117.

Bart, Pauline. "Mother Portnoy's Complaints." *Trans-action* 8:69-74, 1970.

Bart, Pauline, and Marilyn Grossman. "Menopause." Chapter to appear in *The Woman as Patient*, ed. by M. Notman and C. Nadelson. Plenum Press, 1976.

Clyden, J.R., et al. "Menopause Flashing: Double-blind Trial

- of a Non-hormonal medication." *British Med. J.* 1:409-412, Mar. 9, 1974.
- Cowan, B. "Estrogen Therapy Linked to Endometrial Cancer in Postmenopausal Women." *Her-self*, Dec '75-Jan '76.
- Cowan, B. "Questions and Answers on Menopause." *Her-self*, Dec '76-Jan '77.
- Gray Panthers, 3700 Chestnut St., Phil., PA 19104. Activist organization concerned with problems of older citizens, including health care. Founded by Maggie Kahn.
- Greenblatt, R.B., and D.W. Brantner. "Menopausal Headaches—Psychogenic or Metabolic?" *J. of the Amer. Geriatric Society*, 22:186-190, Apr. '74.
- HealthRight, Inc. *Menopause*. Good short pamphlet. Available from HR, 175 Fifth Ave., NY, NY 10010 (25 cents).
- Hess, G. "The Menopause and Breast Cancer." *Lancet*, Mar. 2, 1974.
- Hochschild, A.R. "Communal Lifestyles for the Old." *Society*, V. 18, #5, Aug. '73.
- J. of the National Cancer Institute*. "Menopause and Breast Cancer Risk." 48:605-613, Mar. '72.
- Kistner, E. "The Menopause." *Clinical Obstetrics and Gynecology*, 16:106-129, Dec '73. Presents the typical "establishment" viewpoint. Although Kistner recently has become more cautious about estrogen replacement therapy, many other physicians continue to prescribe estrogen quite freely.
- Lennane, K.J., and R.J. Lennane. "Alleged Psychogenic Disorders in Women: A Possible Manifestation of Sexual Prejudice." *NEJM*, 288, 1973.
- Marshall, B.R. "Postmenopausal Vaginal Bleeding During Estrogen Therapy." *JAMA*, 277:76-77, Jan 7, 1974.
- Masters & Johnson. "Human Sexual Response: The Aging Female and the Aging Male." in *Middle Age and Aging*. Chicago: U. of Chicago Press, 1968.
- McKinlay, S.M. et al. "Selected Studies of the Menopause." *J. of Biomedical Science*, 5:533-555, Oct '73.
- The Medical Letter*. "Drugs, Estrogen and The Menopausal Patient." Jan 19, 1973. Also: "The 'New' Estrogens: Are They Safer?" May 21, 1976.
- Neugarten, B. "Women's Attitudes Towards the Menopause." *Vita Humana*, 6:140, 1963.
- Neugarten, B., and N. Datan. "The Middle Years." in *American Handbook of Psychiatry*, ed. by S. Arieti (2nd ed. V.1). NY: Basic Books, 1974.
- Neugarten, B., and E. Kraines. "Menopausal Symptoms in Women of Various Ages." *Psychosomatic Medicine*, 27:266-273, 1965.
- NOW Task Force on Older Women, 434 96th St., Oakland, CA 94609. Send for literature list and sample copy of their quarterly newsletter. Menopause bibliography is available for 50 cents.
- Prime Time*, An Independent Feminist Journal "for the liberation of women in the prime of life." Available from 420 W. 46th St., NY, NY 10036 (\$7.00/yr.) Excellent publication with lots of feedback/contributions/errors from its readership; frequent coverage on health issues.
- Rubin, Isadore. See "Sexuality" section.
- Ryan, K. and D. Gibson, eds. *Menopause and Aging*. Summary Report and Selected Papers from a Research Conference, May 1971. Hot Springs, ARK. DHEW Publication (NIH) no. 73-319, Bethesda, MD. Includes good discussions of various controversies, though lacks most recent information.
- Smith, D. "Association of Endogenous Estrogens and Endometrial Carcinoma." *NEJM*, Dec 4, 1975.
- Solomon, J. "Menopause: A Rite of Passage." *ME*, 1:16-18, 1972.
- Stern, K. and M. Prados. "Personality Studies in Menopausal Women." *Amer. J. of Psychiatry*, 103: 358-367, 1946.
- Weidiger, Paula. *Menstruation and Menopause: The Physiology and Psychology. The Myth and the Reality*. NY: Knopf, 1976. Comprehensive and well-written. One of the best resources on the topic.
- Williams, C.W. "Clonidine in Treatment of Menopausal Flushing." *Lancet*, June 18, 1973.
- Winkler, G. "Depression in the Menopause." *Am. J. of Psychiatry* 130: 92-93, 1973.
- Zel, H.K. and W.P. Finkle. "Increased Risk of Endometrial Carcinoma Among Users of Conjugated Estrogens." *NEJM*, 283: 1167-1170, 1975.

NUTRITION

- Adams, Carol. *The Oradible Complex: Feminism and Vegetarianism*. Available from To the Lighthouse Press, Box 411, Provincetown, MA, October, 1976.
- Action for Children's Television. *Nutrition Survival Kit*. Good pamphlet for children; encourages them to snack on healthy foods rather than junk. ACT, a non-profit group, has been working to eliminate commercialism from TV, especially TV advertising. Kit is available from ACT, 46 Austin Street, Newsworld, MA 02106 (50 cents).
- Berkeley Women's Health Collective. *Feeding Ourelves*. Includes both useful nutrition information, helpful suggestions and some political discussion. Available from The Collective, 2214 Grove Street, Berkeley, CA 94704, or from New England Free Press, 80 Union Square, Somerville, MA 02143 (free entry).
- Center for Science in the Public Interest. 1755 "S" St. NW, Wash. D.C. 20009. This non-profit, consumer-oriented organization is probably the best single resource in the area of nutrition education and food activism. CSPI publications include the following: *Food for People, Not for Profit*, by Catherine Lerra and Michael Jacobson. Ballantine, 1975 (\$1.95)—An excellent anthology on nutrition, agrifuturism, domestic hunger; discusses how corporate practices influence food prices and the world food crisis; also available on bookstands. *Nutrition Scoreboard*, by Michael Jacobson—Revised Edition, Avon Books, 1975 (\$1.75)—Clear, well-written discussion of nutrition, including the functions of major nutrients and the association between diet and degenerative diseases. Also provides a simple scoring system for determining the nutritional value of common foods. *Creative Food Experiences for Children*, by Mary Goodwin (\$4.00). An excellent collection of games, activities, facts, and recipes that make nutrition and food a lively and exciting topic. Good for parents and teachers in day care centers and elementary schools. *White Paper on Infant Feeding Practices* (\$1.00). Well-documented booklet about infant feeding practices in the U.S. Emphasizes importance of breast-feeding and drawbacks of commercially-prepared baby foods. *How Sodium Nitrite Can Affect Your Health* (\$2.00). Critically examines use of sodium nitrite as an additive in bacon, hot dogs, luncheon meats, and cured fish. *From the Ground Up: Building a Grass Roots Food Policy* (\$2.50). Created to be the handbook for local Food Day activists this terrific guide provides ideas and suggestions, including important nitrgy information, for anyone who wants to work on food and nutrition issues in his/her community. *Food: Where Nutrition, Politics, and Culture Meet—An Activities Guide for Teachers* (\$4.00). *Food Day '78 Newspaper*, from Food Day, Wash. D.C. 20036, 1-9 copies free, 8-page newspaper with many good ideas for organizing around food issues, educating your community about nutrition, etc. Good resource even after Food Day (April 8). *Nutrition Action* (\$10.00/yr. subscription), monthly magazine which covers, in depth, a wide range of food topics; includes editorials, lists of new nutrition/education resources, book reviews, and descriptions of conferences and projects started by activists all over the country. *Nutrition Scoreboard Poster* (\$1.75.) Colorful, eye-catching poster of nutritional ratings for over

- 200 different foods; good for both the home and the classroom.
- Cereal. *Champion of Breakfast?* 4 page feature on cereals, reprinted from the *Co-op News* of December 30, 1974. Up to 100 copies, \$3.05 each plus \$2.25 postage. 100 plus copies, \$3.04 each, plus \$3.50 postage. Groups without funds may request 50-100 copies free. Order from Betty Wood, Co-op, 4805 Central Ave., Richmond, CA 94804.
- CNI Weekly Report. Community Nutrition Institute, 1910 K. St., NW, Washington, DC 20006. Excellent update on government activities related to nutrition (\$25.00 a year) CNI also publishes *Not by Enriched Bread Alone*, an Action Guide for Professional Nutritionists (\$4.00) and *The Proceedings of the National Conference on Food for the Aging*, December 4-7, 1972.
- Composition of Foods, by B.K. Watt and A.L. Merrill. USDA Agriculture Handbook #8, 1963. Order from U.S. Govt. Printing Office (\$2.00).
- DeMarco, Susan, and Susan Sechler. *The Fields Have Turned Brown: Four Essays on World Hunger*. 1975. Well-documented discussion of economic and political causes of world food problems. Available from the Agrifusiness Accountability Project, 1000 Wisconsin Ave., NW; Wash. D.C. 20007 (\$3.50).
- Duffy, William. *Sugar Blues*. Radnor, PA: Chilton Book Co., 1975. Excellent, well-written, sometimes humorous discussion of the effects of sugar on our health.
- "Food Stamp Program." USDA Publication. Explains eligibility requirements and operations of the Food Stamp Program. Free from: Consumer Information Center, Dept. 35, Pueblo, CO 81009.
- Goodwin, Mary. Nutrition Services, Montgomery County Health Department, 611 Rockville Pike, Rockville, MD 20852, offers the following helpful publications: *Better Living Through Better Eating* (\$2.00); *Nutrition Kit for the Community* (\$3.00); *Nutrition Education Course for Secondary School Teachers* (\$2.00); *Can the Poor Afford to Eat?* (50 cents). Send check or money order to: Montgomery County Government.
- Hightown, John. *Eat Your Heart Out: Profiteering in America*. N.Y.: Crown Publishers, 1975. Good discussion of economic and political effects of corporate monopolies on food production.
- Hunter, Beatrice Truman. *Consumer Beware: Your Food and What's Been Done To It*. N.Y.: Simon and Schuster, 1971. Well-documented critique of the food industry. Good chapters on baby foods and food sweeteners; last section explores what consumers can do to improve a bad situation.
- Lappe, Frances Moore. *Diet for a Small Planet*, rev. ed., N.Y.: Ballantine Books, 1975. Gives excellent evidence that meat is an inefficient, sometimes dangerous, source of protein. Describes how to produce high-quality vegetable protein and includes many good recipes (see also *Recipes for a Small Planet*, by Ellen Kwald).
- National Nutrition Policy: *Nutrition, Health and Development*, a working paper compiled by the Subpanel on Nutrition and Health Services for the Select Committee on Nutrition and Human Needs, United States Senate. A particularly good article is called "Physician-induced malnutrition?" Available from Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402 (70 cents).
- Samuels, Mike, and Hal Bennett. *The Well Body Book*. N.Y.: Random House, 1973 (\$5.95). Includes excellent 15-page chapter, "Eating Becomes Fun."
- Science for the People (Health and Nutrition Collective). *Food, Need, Greed—Whose Will It Lead?* High school curriculum unit on population and world hunger. Order from SFP, 16 Union Square, Somerville, MA 02143 (\$1.00).

Self-Help Action Center, 11013 S. Indiana Ave., Chicago, IL 60628. Write for information on how to form direct farmer-consumer links. Their program bypasses wholesalers and retailers, bringing produce to the inner city and other areas at prices beneficial to both farmer and consumer.

Society for the Protection of the Embryo Through Nutrition (SPUN). See Pregnancy and Childbirth Section.

Verrett, Jacqueline, Ph.D., and Jean Carper. *Eating May Be Hazardous to Your Health*. N.Y.: Simon and Schuster, 1974. A research scientist, who has worked over 15 years with the Food and Drug Administration, and a consumer writer describe the corruption and inefficiency within the FDA. They document how the government fails to protect the consumer from dangerous food additives and offer practical guidelines for consumers interested in taking positive action.

Williams, Roger. *Nutrition Against Disease*. N.Y.: Bantam Books, 1973. Well-documented discussion of the relationship between nutrition and disease. Emphasizes how good nutrition prevents illness and how poor nutrition can cause or contribute to certain diseases. Author criticizes lack of nutrition education in medical schools and food industry irresponsibility.

Todkin, John. *Sweet and Dangerous*. N.Y.: Peter H. Wyden, 1972. Bantam, 1973. A professor of physiology presents a strong case against refined sugar.

OCCUPATIONAL HEALTH AND SAFETY

Berman, Dan. *Guide to Worker Oriented Sources in Occupational Safety and Health*. 1974. Full list of groups, union activists and university programs working on health and safety issues. Order from Occupational Health Project, MCHR, 558 Capp St., S. F., CA 94110 (60 cents).

Bertinson, Janet and Jeanne Stollman. *Mercury and Its Compounds. Are They Dangerous?* Order from OCAW, Box 2812, Denver, CO 80202.

Environmental News. Free monthly newsletter. Write to Environmental Protection Agency (EPA), Wash., D.C. 20460.

Hamilton, Alice, and Harriet Hardy. *Industrial Toxicology*. 3rd ed., 1974. One of the basic textbooks in the field, written by two women pioneers.

Hicks, Andrea. Staff-Associate with the Health Research Group, currently at U. of Cal, Labor Occupational Health Program, Institute of Industrial Relations, Berkeley, CA 94720. Has written good articles on women's occupational health problems.

Hunt, Vilma. "Occupational Health Problems of Pregnant Women." Report and Recommendations for the Office of Secretary, Dept. of HEW, 4-30-75. 124 pp. plus appendices.

IED *Spotlight on Health and Safety*. Free bi-monthly from AFL-CIO Industrial Union Department, 815 16th Street, N.W., Wash., D.C. 20006.

Love, Marsha. "The Hazards of Office Work." Available from Health/Fac., 17 Murray St., NY, NY 10007. (25 cents).

MCHR. *Health Hazards in the Workplace*. Order from MCHR, 2251 West Taylor, Chicago, IL 60612 (\$2.00).

Stollman, et al. *Beware, Is It Dangerous?* Order from OCAW, Box 2812, Denver, CO 80202.

Stollman, Jeanne, Ph.D., and Susan Damm, M.D. *Work is Dangerous to Your Health*. N.Y.: Vintage Books, 1973 (\$1.95). Thorough and practical guide to common chemical and physical health hazards.

Stone, Katherine. *Handbook for OCAW Women*. For women in the Oil, Chemical, and Atomic Worker's International Union; includes section on women's occupational health problems. Order from OCAW (address above).

Urban Planning Aid, Occupational Health and Safety Project. Send for their free resource list, "Job Health and Safety Materials." Following are some publications available from

them: *Maternal Women Face*, 76, 12 pp., about conditions of special concern to women, and how they can be dealt with (35 cents); *How to Look at Your Work Place*, '75, (50 cents); *Survival Kit*, bimonthly for workers and workers' groups (\$3.00/yr. or whatever you can afford).

Following is a list of groups concerned with Occupational Health and Safety. They publish useful information and may be otherwise helpful. (List compiled by UPA):

Occupational Health and Safety Project, Urban Planning Aid, 679 Massachusetts Avenue, Cambridge, MA 02139. 617-661-9220.

Health-Pac 17 Murray Street, NY, NY 10017. 212-267-8690
Health Research Group, 2000 P. St. N.W., Washington, D.C. 20036. Site 708. 202-872-0320.

Pittsburgh Area Committee for Occupational Safety and Health (PACOSH) P.O. Box 7566, Pittsburgh, Pa. 15213. 412-824-2698.

Philadelphia Area Project on Occupational Safety and Health (Philaposh) 42 East Logan St., Phil., Pa. 19144 1321 Arch Street, Phila., Pa. 19101 215-568-5188.

Chicago Area Committee for Occupational Safety and Health (CACOSH) 542 So. Dearborn St., Rm. 508, Chicago, Ill. 60605. 312-939-2034.

Labor Occupational Health Project, Institute of Industrial Relations, University of California, 2521 Channing Way, Berkeley, CA 94720 415-642-5507.

Bay Area Committee for Occupational Safety and Health (BACOSH) 594 A Chetwood Street, Oakland, CA 94610. 415-655-4147.

San Diego Committee for Occupational Safety and Health (SD-COSH) P.O. Box 96011, San Diego, CA 92109 714-459-2160.

Occupational Health Project, Medical Committee for Human Rights, 558 Capp Street, San Francisco, CA 94110. 415-282-6623; 285-4452; 824-5888.

School for Workers, University of Wisconsin, 432 N. Lake St., Madison, Wisconsin 53706.

Workers Health and Safety Project, c/o Judy Day, 7184 Manchester St., St. Louis, Mo. 63143, 314-783-7100.

Occupational Health Group, c/o Paul Buchstam, Box 496 and Dede Oudin, Box 373, Case Western Reserve Medical School, 10900 Euclid Ave., Cleveland, OH 44106.

Science for the People, 16 Union Square, Somerville, MA 02143. 617-778-1058.

Union of Concerned Scientists, 1208 Massachusetts Ave Cambridge, MA 02128. 617-547-4490.

PREGNANCY, CHILD BIRTH AND EARLY PARENTHOOD

Groups and Organizations:

The Association for Childbirth at Home (ACAH), 16705 Monte Cristo, Centras, CA 90701. Offers a nationwide referral service for women seeking help with home birth, the educational "Homebirth Series" program, and a monthly newsletter (\$3.00/yr).

The American Academy of Husband-Coached Childbirth, Box 3224, Sherman Oaks, CA 91413. Promotes the principals and practice of natural childbirth as developed by Dr. Robert A. Bradley. Trains and certifies independent Bradley Method childbirth instructors.

ACBO (American College of Home Obstetrics), c/o Gregory White, MD, 2821 Rose St., Franklin Park, IL 60021. National organization of physicians (others are currently excluded) founded to make home births as safe as possible, and to offer support and education to physicians who want to attend home births.

American Foundation for Maternal and Child Health, Inc., 30 Bookman Place, NY, NY 10022. Concerned with public protection against abuses of drugs, interventions and other

obstetric procedures which could cause damage to the fetus, infant, or child in later life. Sponsored two outstanding conferences (send for proceedings).

American Society for Psychoprophylaxis in Obstetrics (ASPO), 1523 E St. NW, Wash, DC 20005. Trains Lamaze teachers and prepares expectant parents in the Lamaze childbirth method.

Book, 5304 Ludlow Dr., Temple Hills, MD 20031. Group concerned with home birth and its impact.

Book Day, Box 228, Cambridge, MA 02138. A group of parents and other individuals that try to help women and their mates interested in home birth and alternatives to hospital birth. They are concerned that women have options about how, where, and with whom they will give birth. Offers preparation classes and monthly meetings to all those interested in alternatives to hospital birth; publishes newsletter (\$3.00/yr).

C/SEC, c/o Melissa Foley, 15 Maynard Rd., Dedham, MA 02026. Educational organization for couples who have had or are planning Caesarian sections. Offers counseling and support groups, works towards changing hospital practices to make childbirth a more family-centered experience.

H.O.M.E. (Home Oriented Maternity Experience), 511 New York Ave., Takoma Park, Wash, DC 20012. Educational organization for couples needing information and support for home birth. Offers classes and is compiling a list of midwives and physicians who will attend home births (send in any names you know of).

International Childbirth Educational Association (ICEA), Box 20852, Milwaukee, WI 53220. Interdisciplinary organization representing a federation of groups and individuals, both parents and professionals, interested in childbirth education and family-centered maternity care. Offers books and newsletters, maintains referral service to classes and family-centered facilities.

International Scientific Lay Non-Medical Midwives for Natural Homebirth, 1304 E. 7th St., Brooklyn, NY 11230. Offers knowledge, support, and encouragement to women planning on home birth. Holds discussions, shows movies and slides, and attends birthing women and their families.

La Leche League International, 9605 Minneapolis Ave., Franklin Park, IL 60131. Organization concerned with breastfeeding. Send for list of available literature, information about local groups.

Maternity Center Association, 48 E. 92nd St., NY, NY 10028. Runs midwifery programs, has opened a domiciliary child-bearing center, and offers a variety of literature (send for list).

Maternity Center Associates, Ltd., 5411 Cedar Lane, Suite 208-A, Bethesda, MD 20014. Home birth service founded by Janet Epstein and Marion McCartney, two nurse-midwives.

NAPSAC (National Association of Parents and Professionals for Safe Alternatives in Childbirth), Box 1307, Chapel Hill, NC 27514. Organization concerned with natural childbirth, childbirth education, alternatives to hospital birth, and family-centered maternity care in hospitals. Annual membership dues (includes subscription to NAPSAC Newsletter) are \$5.00. Proceedings of recent NAPSAC Conference (May '76), book entitled "Safe Alternatives in Childbirth," available for \$5.50 pp.

Resolve, Box 474, Belmont, MA 02178. Group concerned with infertility and related childbearing problems. Offers support groups to women and to couples.

Society for the Protection of the Embryo through Nutrition (SPUN), 17 North Wabash, Suite 603, Chicago, IL 60602.

Important educational organization which provides information and speakers on fundamentals of prenatal nutrition. Publications include "Pregnant?" and "Want a Healthy Child?", a bibliography of scientific studies documenting the role of malnutrition in causing reproductive problems and the protective value of good nutrition on pregnancy outcome, and *SPUN Reports*, a semi-monthly

newsletter covering current maternal and infant care health news.

Publications:

Arns, Suzanne. *Immaculate Deception: A New Look at Women and Childbirth in America*. Boston: Houghton Mifflin Co. and San Francisco: San Francisco Book Co., 1975. Excellent book about the abuse of technology, and intervention in normal childbirth. Points out how hospitals complicate childbirth.

Biring, Gene L. "Recognition of Psychological Stresses Often Neglected in OB Care." *Hospital Topics*, 44 (Sept. '86, pp 100-103).

Birth and the Family Journal, 110 El Camino Real, Berkeley, CA 94705. \$5.00/yr (quarterly). Contains articles about current maternity practices, abstracts and indices to relevant literature.

Boston Area Hospital Survey (Maternity and Pediatric Policies). *Children in Hospitals*, June '75, 31 Wiltshire Pl., Needham, MA 02194. 50 cents. Two-part survey of maternity and pediatric hospital practices in the Boston area, from an informed consumer perspective.

Brody, Jane. "Inducing Labor in Childbirth: 'Permissive Practice' or Safe and Convenient Benefit..." *NY Times*, Mar 10 '76.

Davis, Adelle. *Let's Have Healthy Children*. NY: New American Library, 1972. Good manual for eating well during pregnancy.

Dick-Read, Grantly. *Childbirth Without Fear*, rev. ed. NY: Harper and Row, 1972. By the English doctor who originated "Natural childbirth"; stresses education and relaxation. *The Natural Childbirth Primer*, also by Dick-Read, offers a good guide to labor and delivery.

Haire, Doris. *The Cultural Warring of Childbirth*. Available from ICEA Supplies Center (\$1.00). Excellent critique of American hospital maternity practices in comparison with the best-ranked nations. Includes consumer's guide to calling hospitals.

Harper's Weekly, Special Report on "The Childbirth Revolution," Mar 1-Mar 8, '76 issue. 50 cents from HW, 2 Park Ave. NY, NY 10005. Excellent collection of personal experiences, resources, and information about new childbirth trends, especially home birth.

Hazell, Lester D. *Birth Goes Home*. 1975. Available from ICEA Supplies Center (\$3.00). An ethnographic and attitude study of 300 couples electing home birth in the San Francisco area.

Hazell, Lester D. *Consciousness Childbirth*, rev. ed. '76. NY: Berkeley Windhover Books. Available from ICEA Supplies Center (\$1.95). Probably the best overall childbirth book. Complete, sensible, including good section on home birth. Conveys beautifully what it feels like to give birth.

H.O.M.E. *HOME Oriented Maternity Experience: A Comprehensive Guide to Home Birth*. 1976. Available from H.O.M.E., 511 New York Ave., Takoma Park, Washington, DC 20012 (\$3.00 pp). Good resource, lots on practical considerations of home birth.

Ina May and the Farm Midwives. *Spiritual Midwifery*. 1975. Available from ICEA Supplies Center (\$5.95). Contains accounts of home births attended by self-taught rural midwives on The Farm, commune of about 800 people in Summertown, TN 38403. Of limited practical value; offers a lot on spiritual aspects of birth.

ICEA Supplies Center, Box 70258, Seattle, WA 98102. Publishes *Bookmarks*, an annotated newsletter of books about pregnancy, childbirth, and early child care (updated three times a year); ask to be put on mailing list. Also from ICEA: *ACEA Film and Record Directory*. 1975 ed. (\$2.00) and *ICEA News*, quarterly about trends, changes, current and future events in childbirth education (\$3.00/yr).

Jeffife & Jeffife, et al. "The Uniqueness of Human Milk" (A Symposium). *Am. J. Clin. Nutrition*, V 24 (entire issue), Aug '71. Available through LaLeche League.

Kenda & Williams. *The Natural Baby Food Cookbook*, 1972.

Available from ICEA (\$1.25). Offers inexpensive, nutritious and easy ways to feed babies without commercial baby foods.

Kennel, John H. et al. "Maternal Behavior One Year After Early and Extended Post-partum Contact." *Developmental Medicine and Child Neurology*, V 16, #2, Apr '74, pp 172-9.

Klaus, Marshall H. et al. "Maternal Attachment: Importance of the First Post-partum Days." *NEJM*, V 296, #9, Mar 1, '72.

Klaus, Marshall H. & John Y. Kennel. "Mothers Separated From Their Newborn Infants." *Pediatric Clinics of North America*, V 17, #4, pp 1055-36.

Kitinger, Sheila. *The Experience of Childbirth*, rev. ed., 1972. Available from ICEA Supplies Center (\$2.50). Includes good discussion of psychological aspects of childbirth and parenthood; combines Dick-Read and Lamaze approaches.

La Leche League, Intl. *The Womanly Art of Breastfeeding*, 1963. Available from ICEA Supplies Center (\$3.50). Includes important basic information, though there is a strong sexist message that "a woman's role is to bear and to raise children."

Lang, Raven. *Birth Book*. Palo Alto, CA: Genesis Press, 1972. Order from publishers, Box 11457, Palo Alto, CA 94306 (\$8.00). Includes moving, personal accounts of home deliveries by both men and women; good photographs of labor and delivery.

Maternity Center Association. *Preparation for Childbearing*, 4th ed. 1973. Available from ICEA Supplies Center (\$1.00). Good resource on breathing, relaxation, and exercises for pregnancy, birth, and post-partum.

Mehl, Lewis. "Complications of Home Birth" and "Statistical Outcomes of Home Births in the U.S." Contact LE Mehl, MD, Dept. of Family Medicine, U. of Wisconsin, 777 S. Mills St., Madison, WI 53715. Letter study is available in proceedings to NAPSAC Conference (see NAPSAC).

Myles, Margaret. *Textbook for Midwives*, 8th ed. '75. Available from ICEA Supplies Center (\$15.00). The midwives' "bible."

National Academy of Sciences. *Maternal Nutrition and the Course of Pregnancy* (Final Report and Recommendations), 1970. Available from the Government Printing Office, Wash, D.C.

The National Association for Mental Health. *Primary Prevention of Menstrual Disorders with Emphasis on Prenatal and Perinatal Periods: Action Guidelines*. NAMI, 1800 N. Kent St., Arlington, VA 22209.

Newton, N. & M. Newton. "Psychological Aspects of Lactation," in *Readings on the Psychology of Women*, ed. by J. M. Bandwick, NY: Harper and Row, 1972, pp 277-84.

Nutrition Action Group. "Annotated Pregnancy Nutrition Bibliography." Available free from NAG, 3414 22nd St., San Francisco, CA 94110 (stamped, self-addressed envelopes appreciated). List of 50 articles related to nutrition and pregnancy.

Overs & Foote. *Human Labor and Birth*, 3rd ed., 1975. Available from ICEA Supplies Center (\$13.75). Basic normal obstetrics for medical students.

Perspectives in Maternal and Child Health. Dept. of Hygiene and Public Health, Johns Hopkins University, Rm 1511, 615 N. Wolfe St., Baltimore, MD 21205.

Pfeuder, Robbie. "BACE Attends AFMCH Conference." *BACE Newsletter*, V 12, #5, Sept/Oct '75, pp 2-7. Excellent discussion of a conference on obstetrical intervention and infant outcome. Also good: V 11, #3, May/June '74. Contact BACE, Box 29, Newtonville, MA 02160.

Pryor, Karen. *Nursing Four Baby*, rev. ed., 1973. Available from ICEA Supplies Center (\$1.95). Includes technical information and week-by-week guide.

Ryan, George. "Improving Pregnancy Outcome via Regionalization of Prenatal Care." *JOGN Nursing*, V 3, #4, July/Aug '74, pp 38-40. Standard arguments in favor of regionalization by one of its national proponents.

- San Francisco Interagency Pregnancy Council. *Guidelines for Pregnancy Counseling*. 1975. Order from Family Planning Project, Health Center #4, 1490 Mason St., SF, CA 94122.
- Shaw, Nancy. *Forced Labor: Minority Care in the United States*. NY: Pergamon Press, 1975. Solid analysis of class bias and male physicians' dominance in maternity hospitals.
- Souza, Marion. *Childbirth at Home*. 1978. Available from ICEA Supplies Center (\$7.95). By the mother of 5 children (last two born at home); points out dangers of hospital birth and discusses alternatives. Afterward section includes summary of Santa Cruz Birth Center studies by Lewin Mehl and Gail Peterson.
- Turner, Mary and James. *Making Your Own Baby Food*. 1972. Available from ICEA Supplies Center (\$1.25). Offers alternatives to standard American baby food.
- Urbanowski, Ferris. *Yoga for New Parents/The Experience and the Practice*. 1975. Available from ICEA Supplies Center (\$6.95).
- Ward, Charlotte and Fred. *The Home Birth Book*. 1978. Available from ICEA Supplies Center (\$6.95). Includes many essays covering all aspects of home birth; contributions from Ashley Montagu, Lester Hazell, an obstetrician, a pediatrician, etc., all in strong support of home birth. Beautiful photographs.
- White, Gregory. *Emergency Childbirth*. 1968. Available from ICEA Supplies Center (\$4.00). Primarily for emergency birth attendants but useful for all expectant parents.
- White Paper on Infant Feeding Practices* (see Nutrition section).
- Williams, Phyllis. *Nourishing Your Unborn Child*. 1974. Available from ICEA Supplies Center (\$1.75). Good guide to nutrition in pregnancy.
- Zero Population Growth. "Teenage Pregnancy: A Major Problem for Minors." Single copies of this 4-page report available free from ZPG, 1246 Connecticut Ave NW, Wash, DC 20036. Good compilation of facts and statistics covering birth control, pregnancy, abortion, laws regarding minors, etc.

RAPE

- Brownmiller, Susan. *Against Our Will*. N.Y.: Simon and Schuster, 1975. Offers powerful, well-documented history of rape. A must.
- Burgess, Ann Wolbert and Linda Lytle Holmstrom. *Rape: Victims of Crisis*. Bowie, Md.: Robert J. Brady Company, 1974. (\$6.95, paperback). Good discussion of women's reactions to rape and to the attitudes of the police, the courts, medical personnel, family and friends.
- Center for Women Policy Studies. *Rape And Its Victims: A Report for Citizens, Health Facilities and Criminal Justice Agencies*. An elaborate, well-funded LEAA Project lacking the perspective and input from community-based women's rape groups. Available from Public Information Office, L.E.A.A., Dept. of Justice, 633 Indiana Ave., N.W.; Washington, D.C. 20031.
- Connell, Noreen, and Cassandra Wilson. *Rape: The First Journey for Women*. N.Y.: New American Library, 1974. Contains women's personal testimony and some good essays analyzing various aspects of rape.
- Cowan, Belita. "Congressional Testimony on the Morning-After Pill Before the Senate and House Health Subcommittees." Discusses use of the morning after pill, often prescribed for rape victims. Available for \$1.00 from B. Cowan, 556 Second Street, Ann Arbor, MI 48103.
- Feminist Alliance Against Rape (FAAR). Box 21033, Washington, D.C. 20009. Excellent bimonthly, *FAAR Newsletter*, subscription \$5.00/year.
- Goffin, Susan. "Rape: The All-American Crime." *Ramparts Magazine*, 10 (September, 1971), pp. 28-35. An excellent article which explores rape in its political and social context. Also available from KNOW, Inc.
- Hesse, Carol V. *Rape*. Tobey Publishing Co., Box 428, New Canaan, CT 06840, 1974. (\$2.95). 70% discount available to non-profit groups; order from publisher including payment and IRS tax exempt number. Covers many aspects, but lacks discussion of rape as a product of our culture.
- Medea, Andra, and Kathleen Thompson. *Against Rape*. N.Y.: Farrar, Straus and Giroux, 1974 (\$2.25). An excellent, comprehensive book written by two women involved in a rape crisis center. Covers prevention and treatment of rape and describes how societal values are the basic cause of rape.
- Pennsylvania Commission for Women. "Help for the Rape Victim." 1975. Single copies available in Spanish or English by sending stamped, self-addressed envelope to the Commission, 512 Finance Bldg., Harrisburg, PA 17128.
- Rape Crisis Center. "How to Start a Rape Crisis Center." Box 21005, Kalorama Street Station, Wash., D.C. 20009 (\$3.50).
- Russell, Diana E. *Politics of Rape: The Victim's Perspective*. N.Y.: Stein & Day, 1975.
- Southern, Sandra, and Donald Schert, M.D. "Patterns of Response Among Victims of Rape." *Journal of Orthopsychiatry*, Vol. 40, No. 3 (April, 1970).
- Women Against Rape. *Stop Rape*. Good pamphlet, includes self-defense techniques. Available from Women Against Rape, 16141 Marlowe, Detroit, MI 48235 (\$1.00).
- Women Organized Against Rape. Their training packet is available for \$5.00, from WOAR, Box 17374, Phil., PA 19105.
- Women's Crisis Center. "How to Organize a Women's Crisis-Service Center" (\$1.75); and *Freedom From Rape* (50 cents); write WCC, Rape Education Committee, 306 North Division, Ann Arbor, MI 48108.

RESOURCES ON SELECTED ISSUES

- American Cancer Society, 219 E. 42nd St., NY, NY 10019. Send for brochures on breast self-exams, uterine cancer, etc.
- Boston Women's Health Book Collective. "Breast Problems and Breast Cancer" section in *Our Bodies, Ourselves*, new '76 edition.
- Coalition for the Medical Rights of Women. "DES Information." Available free from the Coalition's DES Committee, 433 Turk St., SF, CA 94102 (send stamped self-addressed envelope).
- Breast Cancer Advisory Service. Offers information, counseling, and support. Box 422, Kensington, MD 20795. Hotline number: 301-897-8808.
- Cyle, George Jr. MD. *What Every Woman Should Know About the Breast Cancer Controversy*. NY: Pocket Books, 1974.
- Dalton, Katherine. *The Menstrual Cycle*. NY: Pantheon, 1969. Comprehensive book on menstruation and menstrual problems (hormonal treatments suggested are questionable).
- Denenberg, Herbert. "A Shopper's Guide to Surgery: 14 Rules on How to Avoid Unnecessary Surgery." Available from the PA Dept. of Insurance, Harrisburg, PA 17120.
- Fried, John J. "Viewpoint on Hysterectomy." *Playgirl*, Sept. '74. Well-written, well-documented article.
- Giddens, Dorothy. "Fact Sheet on Breast Surgery." Available from FWHOC, 1112 Crenshaw Blvd. LA, CA 90019 (50 cents).
- Greenwald, Peter. MD. "Congressional Testimony on DES Before the Senate Health Subcommittee." Available from the author, Director, Cancer Control Bureau, Dept. of Health, State of NY, Albany, NY 12208.
- Herbst, Arthur L., et al. "Effects of Maternal DES Ingestion on the Female Genital Tract." *Hospital Practice*, Oct. 1975, pp. 51-57.
- Larned, Deborah. "The Greening of the Womb." *New Times*, Dec 12, 1974. Good article on hysterectomy.
- MacMahon, B. et al. "Etiology of Human Breast Cancer: A Review." *J. of National Cancer Inst.*, 50: 21-42, 1973. Excellent resource on the epidemiology of breast cancer.
- Parlee, Mary Brown. "Stereotypic Beliefs about Menstruation: A

- Methodological Note on the Moon Menstrual Distress Questionnaire and Some New Data." *Psychosomatic Medicine*, 36(3), May/June, 1974, 229-240.
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- Parlee, Mary Brown. "The Premenstrual Syndrome." *Psychological Bulletin*, 80, 454-465, 1973.
- Ritter, Esther. "Effects of Herbicide Use on Food Production, People and the Planet." Available from Natural Organic Farmers' Association, c/o Ritter, RD 1, Vergennes, VT 05491 (\$0 cents.)
- Stephens. "A Cross-Cultural Study of Menstrual Taboos." *Genetic Psychology Monographs*, 64, 385-416, 1961.
- Well-Being, a Healing Magazine. Box 7455, San Diego, CA 92107. Includes many fine, simply-written articles on balanced living and on alternative solutions to our health problems (\$5/yr).
- Women for Sobriety. A group of women trying to help alcoholics and problem drinkers. They run support groups and put out a newsletter (35/yr). Write: 344 Franklin St., Quakertown, PA 18951.

SELF-HELP AND WOMEN'S HEALTH MOVEMENT

- Boston Women's Health Book Collective. *Our Bodies, Ourselves*. N.Y.: Simon and Schuster, rev. 1976 (\$4.95). Covers wide range of topics about women's health care and sexuality. Includes section on deciding about parenthood. Newly revised and expanded to 384 pages. 75% clinic copy discount available to clinics having IRS tax exempt number and official document verifying health service status. Send preceding information along with payment to Clinic Copies, Simon and Schuster, 630 Fifth Ave., N.Y., N.Y. 10020.
- Campbell, E., and V. Ziegler, eds. *Circle One: A Woman's Reasoning Guide to Self Health and Sexuality*. 2nd ed. Mar. '75. Available from Circle One, Box 7211, Colorado Springs, CO 80933 (\$3.00).
- Cowan, Bette. *Women and Health Care: Resources, Writings, Bibliographies*. Order from B.C., 556 2nd St., Ann Arbor, MI 48103 (\$3.00). Superb resource for both individuals and groups. Newly revised, 1976.
- Feminist Women's Health Center, 1112 Crenshaw Blvd., L.A., CA 90019. Send for excellent literature list. Publications include "How to Start Your Self-Help Clinic" (\$2.50); "FWHC Annual Report," V.1, No. 2, 1975; includes up to date resources on self help, written in Spanish and English.
- Frankfort, Ellen. *Vaginal Politics*. N.Y.: Bantam Books, 1971.
- Gilmore, Mickey. *The Nurse and Family Planning: A Manual for Counseling, Patient Advocacy, and Clinical Care*. Available from Emory University Family Planning Program, Dpt. of OB-GYN, School of Medicine, Atlanta, GA 30303 (\$3.00).
- HealthAlert, 175 5th Avenue, N.Y., N.Y. 10003 Quarterly women's health newsletter (\$5.00/yr). Excellent coverage of women's health issues for consumers, health workers, and health activists.
- Herself (newspaper), 225 East Liberty Street, Ann Arbor, MI 48103 (\$4.00/yr). Offers excellent coverage of women's health issues.
- Horrstein, Frances. "An Interview on Women's Health Politics," Parts I and II. *Quest*, Vol. 1, No. 1 (Summer, 1974); and Vol. 1, No. 2 (Fall, 1974). A discussion of aspects of the political consciousness of feminist women's health centers. Available from *Quest*, 1909 Q St. NW, Wash., D.C., 20009 (\$2.00 per issue).
- Howell, Mary. *Helping Ourselves: Families and the Human Network*. Boston: Beacon Press, 1975. Excellent; strong self-help focus.
- Kaiser, Barbara and Irwin. "The Challenge of the Women's Movement to American Gynecology." *American Journal of Obstetrics and Gynecology*, No. 74.
- Marleskind, Helen. "Gynecological Services: The Historical Relationship to the Women's Movement with Recent Experiences of Self-Help Clinics and Other Delivery Modes." Ph.D. Dissertation, UCLA School of Public Health. Written from a feminist perspective. Available through University Microfilms, or at Box 210, Old Westbury, N.Y. 11568 (\$10.00).
- Medical World News. "Women's Liberation and the Practice of Medicine," June 22, 1973, pp. 33-38. Good early article describing the medical establishment's reactions to the women's health movement.
- New England Free Press, 60 Union Square, Somerville, MA 02143. Send for free literature list, which includes section on women's health.
- New Moon Publications, Box 3488, Ridgeway Station, Stamford, CT 06905. Publishes *The Monthly Extrav* (\$5.00) and other women's health literature. Send for list.
- Of Our Books, 1724 20th St. NW, Wash, DC 20009. Feminist newspaper with good health coverage (\$4.00/yr.).
- Rao, Karen. "And Now, the 'Liberated' Women Patient." *AMA News* (October 7, 1974), pp. 14 ff. Physician-oriented discussion of the women's health movement, a response to doctors' alleged conclusion over what women want.
- Palo Alto Self-Help Collective. "Self-Help." Booklet available for a donation from Our Health Center, 270 Grant, Palo Alto, CA 94306.
- Pendleton, Elaine, CNM. *Family Planning Procedure Manual for Nurse-Midwives*, 1975. Order from author, Box 24, Department of OB-GYN, Downstate Medical Center, 450 Clarkson Ave., Brooklyn, NY 11203 (\$2.00).
- Proceedings, 1974 Phil. Conference on Women and Health. Co-sponsored by the SE PA Dept. of Health and the PA Commission for Women. To ask about available copies, write to Johanne Fisher Wolf, Rm 1300, 1400 Spring Garden, Phil. PA 19130.
- Renke, Susan, and Kirsten Grimstad. *The New Woman's Survival Sourcebook*. N.Y.: Alfred Knopf, 1975 (\$5.00). Includes a good section on women's health.
- Reynard, Muriel. *Gynecological Self-Help: An Analysis of its Impact on the Delivery and Use of Medical Care for Women*. Master's thesis at SUNY Stony Brook, 1973. Available from University Microfilms, Ann Arbor, MI.
- Ross, Susan. "A Woman's Right to Control Her Body" in *The Rights of Women* (ACLU Guide). NY: Avon, 1973 (\$1.25).
- Ruzek, Sheryl. *Women and Health Care: A Bibliography With Selected Annotated June '75*. Order from: The Program on Women, Northwestern University, 619 Emerson St., Evanston, IL 60201. (\$3.50). One of the best bibliographies to date.
- Santa Cruz Women's Health Collective. "The Self-Help Booklet." Order from The Collective, 250 Locust St., Santa Cruz, CA 95060. (Send donation).
- Second Wave magazine, Vol. 2, No. 3 (Summer 1972). Contains many good articles on the history of women as healers, on self help, on rape, testimony of medical students about mistreatment of patients at Boston City Hospital, experiences of women who have had illegal abortions. An excellent issue. Order from SW, Box 344, Cambridge, MA 02139 (\$1.00).
- Sister Courage, Box 296, Alton, MA 02134. Boston-area feminist newspaper with good women's health coverage. Ask for back copies, especially the January 1976 issue, which contains an excellent article on forced sterilization (\$4.00/yr).
- Social Policy. Special issue on Women and Health. September-October, '75. Includes "Restructuring OB-GYN," by Helen G. Marleskind.
- Sprague, Jane. "Women and Health Book Shelf." *A.J.P.H. July, 1975*, V. 65, No. 7. Good 7-page bibliography.
- Triple Jeopardy, Third World women's health organization which publishes a newsletter by the same name. For information write to them at 1613 Belton, Phil, PA 19149.



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 SUFFRAGIST, (1860-1958)

1975 CONFERENCE ON WOMEN AND HEALTH

APRIL 4-7, 1975 BOSTON, MASS

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