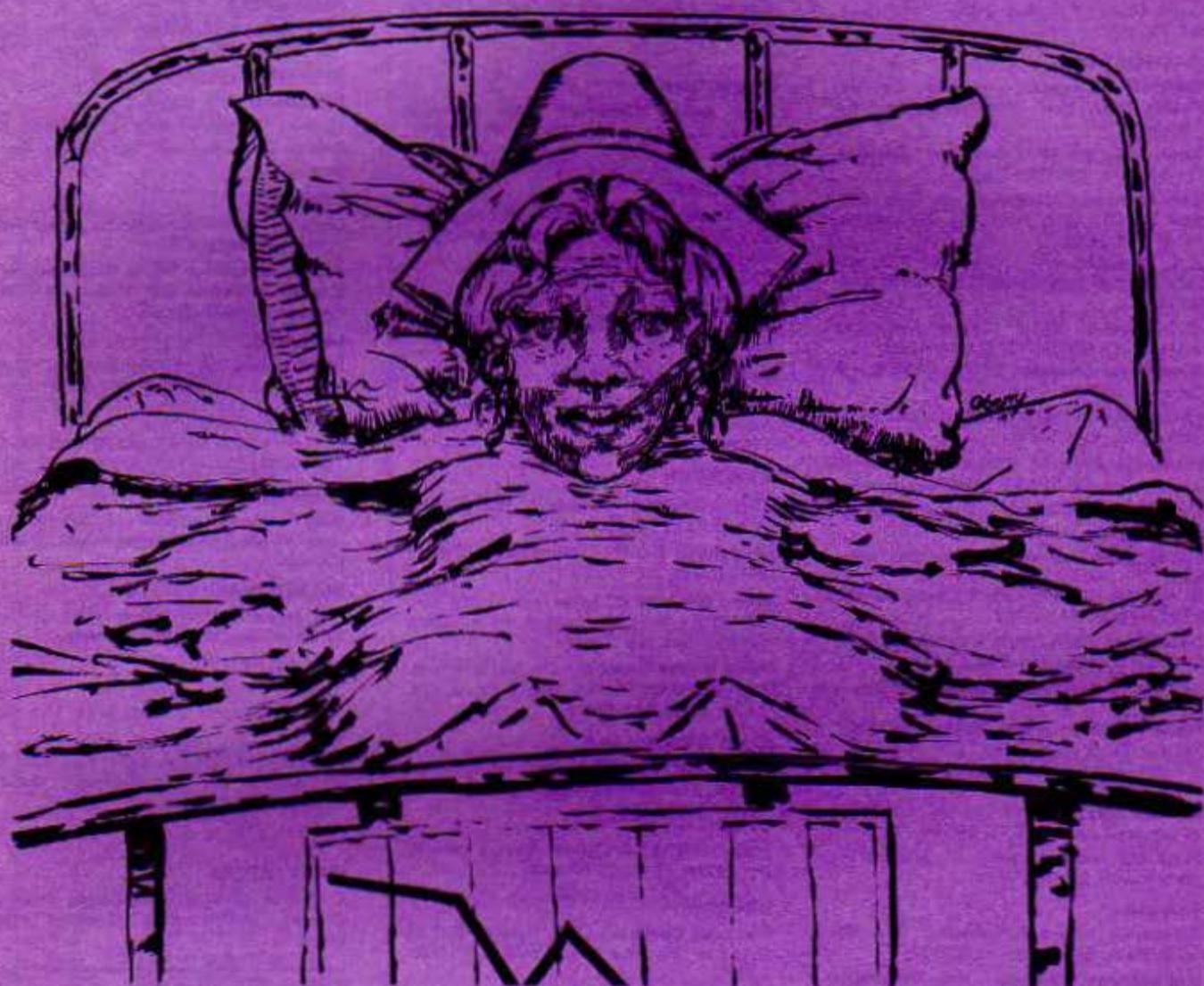


# SCIENCE FOR THE PEOPLE

May/June 1978 Vol. 10 No. 3 \$1



## The False Promise: Professionalism in Nursing

LESBIAN HEALTH ISSUES

Seabrook '78 • Science Teaching

## CHAPTERS AND CONTACTS

Science for the People is an organization of people involved or interested in science and technology-related issues, whose activities are directed at: 1) exposing the class control of science and technology, 2) organizing campaigns which criticize, challenge and propose alternatives to the present uses of science and technology, and 3) developing a political strategy by which people in the technical strata can ally with other progressive forces in society. SftP opposes the ideologies of sexism, racism, elitism and their practice, and holds an anti-imperialist world-view. Membership in SftP is defined as subscribing to the magazine and/or actively participating in local SftP activities.

### ARKANSAS

Joe Neal, P.O. Box 1772, Fayetteville, AR 72701.

Dotty Oliver, P.O. Box 2641, Little Rock, AR 72201.

### CALIFORNIA

**Berkeley Chapter:** Science for the People, P.O. Box 4161, Berkeley, CA 94704.

Kevin Cadogan, 1033 Rose Ave., Oakland, CA 94611. (415) 658-7263.

**San Francisco Chapter:** Lou Gold, P.O. Box 34-161, San Francisco, CA 94134. (415) 584-0992.

**L.A. Chapter:** c/o Al Heubner, P.O. Box 368, Canoga Park, CA 91303. (213) 347-9992.

Shel Plotkin, 3318 Colbert Ave., Los Angeles, CA 90066. (213) 391-4223.

**Santa Cruz Chapter:** P.O. Box 854, Santa Cruz, CA 95060.

Paulo Dice, Thimann Laboratories, U.Ca., Santa Cruz, CA 95064.

Michael J. Williams, 328 51st St. No. 2, Sacramento, CA 95819. (916) 456-3647.

David Schnitzer, 808 Roberto Ave., Santa Barbara, CA 93109. (805) 966-2057.

Sedley Josseland, 491 Spruce St., Riverside, CA 92507. (714) 784-3704.

Al Weinrub, 104 So. 16th St., San Jose, CA 95112. (408) 292-2317.

Dave Offen, 2044 Oakley Ave., Menlo Park, CA 94025. (415) 854-2422.

Edie Bragg, Box 234, Ocotillo, CA 92259.

**Davis Chapter:** c/o P. Hardt, 318 J St., No. 40, Davis, CA 95616.

### CONNECTICUT

N. Sadanand, Dept. of Physics, University of Connecticut, Storrs, CT 06268.

Neal and Margie Rosen, 71 Stanley St., New Haven, CT. 06511.

### FLORIDA

Gainesville Research Collective, 630 NW 34th Place, Gainesville, FL 32601.

**Tallahassee Chapter:** c/o Progressive Technology, P.O. Box 20049, Tallahassee, FL 32304.

### ILLINOIS

**Chicago Chapter:** c/o Ivan Handler, 2522 N. Washtenau, Chicago IL 60647.

**Urbana-Champaign Chapter:** 284 Illini Union, Urbana, IL 61801. (217) 33-7076.

### IOWA

Paul C. Nelson, 604 Hodge, Ames, IA 50010. (515) 232-2527.

### MASSACHUSETTS

**Amherst Chapter:** P.O. Box 599, N. Amherst, MA 01059.

Marvin Kalkstein, University Without Walls, Wysocki House, University of Massachusetts, Amherst, MA 01002.

**Boston Chapter:** Science for the People, 897 Main St., Cambridge, MA 02139. (617) 547-0370.

### MICHIGAN

**Ann Arbor Chapter:** 4104 Michigan Union, Ann Arbor, MI 48109. (313) 971-1165.

### MISSOURI

**St. Louis Chapter:** Craig Norberg, c/o Dan Bolef, Dept. of Physics, Washington University, St. Louis, MO 63130. (313) 533-1936.

Joe Eker, Rm. W-137, Box 29, Univ. of Missouri Medical Center, Columbia, MO 65201.

### NEW HAMPSHIRE

Steve Cavrak, Environmental Studies Program, Franconia College, Franconia, NH 03580.

### NEW YORK

Marvin Resnikoff, 84 DeWitt St., Buffalo, NY 14213. (716) 884-0497.

Tedd Judd, Dept. of Psychology, Cornell Univ., Ithaca, NY 14853.

**New York City Chapter:** c/o D.S.C. Rm. 208, CUNY Graduate School, 33 W. 42nd St., New York, NY 10036.

**Stony Brook Chapter:** c/o Ted Goldfarb, Chemistry Dept., SUNY, Stony Brook, NY 11794. (516) 246-5053.

### NORTH CAROLINA

Marc Miller, 2 Pine Tree Lane, Rt. 2, Chapel Hill, NC 27514. (919) 493-1767.

### OHIO

Jenny Thie, 2147 Fulton Ave., Cincinnati, OH 45206. (513) 281-6149.

### OREGON

**Portland Chapter:** Craig Newby, 920 SE 31st Ave., Portland, OR 97214. (503) 235-1277.

### VIRGINIA

Kenneth Solomon, MD, Dept. of Psychiatry, Medical College of Virginia, Richmond, VA 23298.

### WASHINGTON

David Westman, 919 2nd Ave. W. No. 604, Seattle, WA 98119.

Phil Bereano, 316 Guggenheim FS-15, Univ. of Washington, Seattle WA 98195. (206) 543-9037.

### WISCONSIN

Cal Pierce, 525 W. Dayton No. 2, Madison, WI 53703. (608) 255-7019.

## Chapters and Contacts Outside U.S.

### AUSTRALIA

Tony Dolk, 234 Bobbin Head Rd., North Turramurra, New South Wales, 2704 Australia.

### BELGIUM

Gerard Valenduc, Centre Galilee, B.P. Balilee 047, B-1348 Louvain-La Neuve, Belgium.

### ENGLAND

Dave Hayes, 14 Goodwin Rd., Sheffield 8, Yorkshire, England.

British Society for Social Responsibility in Science, 9 Poland St., London, W1V3DG, England. 01-437-2728.

### IRELAND

Hugh Dobbs, 28 Viewmount Park, Waterford, Eire. Phone 051-75757.

### INDIA

D. L. Surendra, 3B, Thandava Raya St., San Thome, Madras-4, India.

### QUEBEC

Bob Cedergren, Dept. of Biochemistry, Univ. of Montreal, Montreal 101, Quebec, Canada.

### MANITOBA

Roy Johnstone, c/o Argyle High, 30 Argyle St., Winnipeg, Manitoba, Canada.

### ONTARIO

Allan C. Vaisius, 2555 Bloor St. West, Toronto, Ontario, Canada M6S 1S1. 828-5271.

Radical Anthropology Collective, P.O. Box 25, Station "A", Scarborough, Ontario, Canada M1K 5B9.

### WEST INDIES

C. Raymond Mahadeo, Caroni Research Station, Carapichaima, Trinidad, West Indies.

---

A chapter consists of three or more people meeting regularly. If you want to help start a chapter or be a contact person for your area, please contact Science for the People, 897 Main St., Cambridge, MA 02139. Tel: (617)547-0370.

---

**COVER:** The illustration for our cover is the work of O. Berry, a Boston-based artist. People interested in seeing more of his work can reach him through the Boston Science for the People office.

---

## Science for the People

897 Main Street  
Cambridge, Mass. 02139

### MAGAZINE COMMITTEES

#### Production

Boston Nurses' Group  
Chip Bruce  
Ed Egelman  
Ross Feldberg  
Jim Flowers  
Mimi Halperin  
Hiroshi Inouye  
JoAnn Jaffe  
Diane Lande  
Bob Lange  
Peggy Lester  
Lila Liebowitz  
Ed Loechler  
Jim Moore  
Bob Park  
Connie Phillips  
Martha Robb  
Freda Salzman  
Bent Schmidt-Nielsen  
Will Simard  
Rachel Skvirsky  
Sue Tafler  
Scott Thacher  
Ray Valdés  
Peter Ward  
Glenn Wargo  
Mark Wilson

#### Editorial

Kathy Greeley  
Dick Leigh  
Steve Nadel  
Connie Phillips  
Scott Schneider  
Tallahassee Chapter  
Scott Thacher  
Jim Tobias  
Ruth Weinstein  
Mark Wilson

#### Distribution

Bob Park  
Ray Valdés  
Peter Ward  
Glenn Wargo

**Office Coordinator**  
Kathy Greeley

**Magazine Coordinator**  
Eric Entemann

- 2 Chapters and Contacts
- 4 About This Issue
- 5 Letters
- 6 Resources *by Tallahassee SftP*
- 8 Lesbian Health Care: Issues  
and Literature *by Mary O'Donnell*
- 20 The False Promise: Professionalism  
in Nursing *by the Boston Nurses Group*
- 35 S.T.G. Goes to School  
*by the Ann Arbor SftP Science Teaching Group*
- 36 Summer at Seabrook—Clamshell Will  
Return in Force *by Frank Bove*
- 38 News Notes

*Science for the People* magazine is published bimonthly by the national organization Science for the People (see facing page for chapters and contacts). Our address is 897 Main Street, Cambridge, MA 02139. Tel: (617) 547-0370. We welcome contributions of all kinds: articles, book reviews, artwork, cartoons, etc. Please see our editorial guidelines on the inside back cover. *SftP* is intended for all people interested in a progressive and radical view of science and technology. Our subscription rates are \$6 per year (regular subscribers) and \$15 a year or whatever you can afford (member subscribers). Member subscribers receive the magazine plus our internal newsletter and other internal communication. For legal purposes, *Science for the People* is incorporated. *SftP* is available in microfilm from Xerox University Microfilms, 300 North Zeeb Rd., Ann Arbor MI 48106.

Unless otherwise stated, all material in this magazine is copyright 1978 by Science for the People.

# about this issue

In this issue we are printing two articles that focus on women and health care, one about professionalization of nurses and one about lesbian health issues. Both of these articles raise questions concerning the control of the quality and direction of health care in the US. How much control do workers and patients have in determining the nature of their health care system? As these articles point out, alienation of groups of workers from one another in the health care industry and the economic and personal oppression of patients are fostered by health care under capitalism.

Disunity of workers is facilitated by professionalization of nurses. The requirement for college degrees and graduate training changes the class composition of nurses, causes more stratification, and widens the gulf between nurses and other health maintenance workers. Women who have access to college and graduate training will enter specialty fields in nursing and become practitioners, while working class women will make up a large percentage of aides, LPNs, and laundry, dietary, and cleaning staff.

In their article, the authors tell how organizing efforts have been held back by nurses' professional organizations, which operate to weaken the ties among hospital workers and enforce elitist and non-union attitudes. Professionalism obscures the basic class relation: that of those who own and control the means of production and those who depend on this group for their jobs. Cutbacks in health care spending cause reductions in staff and overworking of those who remain. Nurses are frustrated by their lack of power and the little room they have to make creative decisions. At the same time, specialization, mobility, and higher salaries tend to make nurses feel closer to the class to which in the last analysis they really do not belong. It is in the interest of nurses to unite with other workers to gain more control in their workplaces.

\*\*\*\*\*

SftP has always supported people who have been oppressed and are now struggling to take control over their own lives. Our second feature article is "Lesbian Health Care: Issues and Literature" by Mary O'Donnell of the Santa Cruz Women's Health Collective. While SftP has published several articles on progressive women's issues, this is the first article we have ever considered that focuses specifically on lesbian rights.

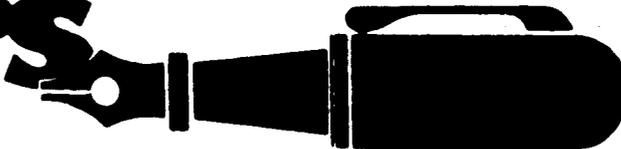
We felt that the article was important in two ways: as a consciousness-raising tool for those who have never considered the pressures and problems of being gay and as an informational piece for both gays and heterosexuals. O'Donnell describes the overwhelming discrimination against lesbians in a health care system which has strong male and heterosexual biases. She shows how these biases interfere in several ways with the accessibility of good health care for lesbians, and carefully reviews the information and literature in three specific areas — gynecology, reproduction and mental health.

We feel that lesbians and lesbian issues have been an important part of the Women's Movement, which has played an instrumental role in building a foundation for progressive social change in this country. We realize that there are different kinds of feminism, some of which do not challenge the roots of social inequality; for example, women moving into corporate executive positions really does not affect the fundamentals of power and sexism. Many issues have been raised by women which do threaten existing social and economic relations under capitalism. Lesbianism challenges traditional notions of sexuality and family structures. Just how threatening these have been is evidenced by the recent rash of repressive actions directed against women — the reactionary legislation concerning abortion, the harassment of feminist health clinics, the outrageous rulings on rape, the increasing backlash against gay rights. Especially now, in the face of the current resurgence of the Right, it is crucial for all liberation struggles, all progressive movements to work together. We feel that it is important for *all* people committed to social change to support lesbians in their struggle for decent health care and freedom from discrimination in all aspects of their lives. □

## CLARIFICATION

The article entitled "Drug Abuse and the Medical Profession: The Lilly Connection," which appeared in the Jan./Feb. issue of *Science for the People*, had already been published in a slightly different version by *State and Mind* (Fall 1977 issue). We were not aware that the author had submitted his article to *State and Mind*, and apologize for what appeared to be our use of the article without proper credit to *State and Mind*.

# letters



Dear SftP,

Wish there was more writing on science and engineering than on politics. There seem to be too many internal problems within SftP. Articles should be shorter; I don't have time to read thru a lot of pages to get 2 or 3 paragraphs of "meat." Magazine doesn't have to be 30 pages in length each issue.

Bruce Bockin

Dear SftP,

I want to congratulate you on your wonderful contributions in pointing up some of the more critical issues in science today, within the socio-political context. Your presentations are clear and easy to follow, even for one who is not a scientist.

Whether it be genetics, infant malnutrition or environmental problems you seem to be always on target. I am delighted that you are now making an attempt to broaden your circulation. May I suggest that an effort be made to improve the layout and makeup of the publication. I would imagine that within the Harvard-MIT-Tufts complex there is someone who would want to contribute his/her talents to making the appearance of SftP somewhat more modern and more compatible with the quality of the editorial contents.

S. Chavkin  
New York, NY

Dear SftP,

New format is a great improvement. I like the increased number of articles about women's issues. We need to discuss who we want the magazine to reach. Use of lots of political jargon and the like turns off many of my colleagues who would otherwise be allies.

Paulo Dice  
Santa Cruz, CA

Dear SftP,

In the editorial page of the Nov./Dec. 1977 issue of *Science for the People*, we can read the following: "Corporation profits come out of debt to the natural and social environment, and requiring corporations to repay this debt by cleaning up their act would put them out of business. Business pleads layoffs and

Federal inspectors lessen or ignore existing occupational and environmental standards, because a capitalist economy cannot accommodate large numbers of workers that would be out of jobs."

There are three fallacies inherent in the above statement. Fallacies which are not necessarily deliberate, but, rather, hasty "conclusions" drawn from the erroneous misconception which attempts to characterize the fundamental contradiction of History as a struggle between Man and Nature. These fallacies are:

(1) "Corporation profits come out of debt to the natural and social environment . . ."

(2) ". . . to repay this debt by cleaning up their act would put them out of business."

(3) ". . . a capitalist economy cannot accommodate large numbers of workers that would be out of jobs."

Drawing hasty "conclusions" is dangerous. Dangerous because it creates illusions of reality; because it distracts us from the problems at hand and sends us chasing after non-entities. Dangerous because it looks at form and not essence.

**First:** Profits are derived from the unpaid social labor of the working class. Profits do not derive from any "debt" to the natural environment: nature creates forms of value, but never profits. It is only man's labor, in the form of social production, which creates that surplus-value from which the capitalist appropriates "his" profit, the financier "his" interest, and the landowner "his" rent. Obviously, as long as the capitalists are able to abuse and plunder our social property, they can maintain their costs of production down. However, it does not necessarily follow that their profits decrease when their costs of production increase. Labor and material costs have risen since the inception of the Industrial Revolution. However, on the average, monopoly capitalists have not seen their profits decrease.

**Second:** Capitalism does not of its own accord relegate itself to the museum of History. It never has, and it never will, without a fierce struggle. Monopoly capitalists do not go out of business

when they install anti-pollution equipment. In fact, the anti-pollution business opens up new avenues of investment for them, new opportunities to branch out, as the ads in the trades publications clearly document! When they do install anti-pollution equipment, it is for them a tremendous public-relations event — "corporate responsibility," "good-will," etc., etc. You must also realize that just as the early capitalists were "charitable" enough to have sewers and other "menities" installed in the squalid workers' neighborhoods to prevent classless epidemics originating therein from infecting their bourgeois neighborhoods, so too, today's bourgeoisie realizes that the winds and waters know no class-borders: the garbage and poisons they dump in the workers' cities will eventually find their way to their sanctuaries. Hence, they too must take measures.

**Third:** Capitalism can and does accommodate large numbers of unemployed workers. An unorganized contingent of unemployed workers allows the capitalists to lower wages — "supply and demand" — and thus, lowers one of their costs of production; pits worker against worker, creates divisions and sows confusion.

Profits are derived from the unpaid labor of the working class. This class not only suffers the daily exploitation of its social, productive labor, but is also the first one to pay the nefarious consequences of the rapacious and anarchistic exploitation of the Earth by the capitalists: unsafe machinery, toxic atmospheres, degrading working environment and mental coercion. The working class does not fear nor oppose science and technology: it realizes and recognizes that, like everything else in this world, science and technology are branded with a class character. Science, in the hands of the people, will no longer serve to oppress and poison us, but will become a powerful tool in the construction of a New World and a New Man.

C. Duarte  
Elizabeth, N.J.

LETTERS, continued on p. 39

# resources

Please send your items and suggestions for this column to Tallahassee SftP, c/o Progressive Technology, P.O. Box 20049, Tallahassee, FL 32304.

*Medicine Under Capitalism*, Vicente Navarro, 1976, 230 pp, \$6.50. Published by Prodist, a division of Neale Watson Academic Publications, Inc.; 156 Fifth Avenue; New York, New York 10010. A Marxist study of medical care in the Americas. Includes essays on the underdevelopment of health care in Latin America and in the rural and urban-working U.S. . . . on women as producers of services in the health sector . . . a critique of Ivan Illich, etc.

*Rainbook: Resources for Appropriate Technology*. By the editors of RAIN, 1977, 251 pp (large), illustrated, Schocken Books, A directory that will get one in touch with information and resource people in such areas as appropriate technology, agriculture, shelter, health, recycling, energy, transportation, community building and economics. For an on-going update subscribe to RAIN; 2270 N.W. Irving; Portland, OR 97210. Monthly. \$10/year.

The *Southeast Asia Chronicle* (\$8/year, formerly *Indochina Chronicle*) gives coverage to the progress being made by the people of Southeast Asia to rebuild their countries. This is the periodical to read if one wants to find out how Americans can contribute by supporting such programs as Friendship, Penicillin for Vietnam, and others. Also they provide otherwise hard to find information . . . for example they have a special issue on "Cambodia: The Politics of Food" (\$.75) which was recently expanded and published as the book *Cambodia: Starvation and Revolution* (6.95, distributed by them). Southeast Asia Resource Center; P.O. Box 4000-D; Berkeley, California 94704.

*The Radicalisation of Science and The Political Economy of Science*. Both volumes are subtitled "Ideology of/in the Natural Sciences". Edited by Hilary and Steven Rose, Macmillan (London), 1976. Available to the U.S. reader via Holmes & Meier Publishers; Import Division; 101 Fifth Avenue; New York, New York 10003 for \$23 per volume (so

try to get the library to buy it). The table of contents goes like so . . . *Radicalisation*, "Radicalisation of Science" (H&S Rose), "Problem of Lysenkoism" (Lewontin & Levins), "Women in Physics" (Couture-Cherki), "Sciences, Women and Ideology" (Stehelin), "History and Human Values: Chinese Perspective for World Science & Technology" (Needham), "Science, Technology and Black Liberation" (Anderson), "Ideology of/in Contemporary Physics" (Levy-Leblond), *Political Economy*, "Problematic Inheritance: Marx and Engels on the Natural Sciences" (H&S Rose), "Incorporation of Science" (H&S Rose), "Production of Science in Advanced Capitalist Society" (Ciccotti, Cini & De Maria), "On the Class Character of Science and Scientists" (Gorz), "Contradictions of Science and Technology in the Productive Process" (Cooley), "Politics of Neurobiology: Biologism in the Service of the State" (H&S Rose), "Scientific Racism and Ideology: The IQ Racket from Galton to Jensen" (S. Rose), "Women's Liberation: Reproduction and the Technological Fix" (H. Rose and J. Hanmer), "Critique of Political Ecology" (Enzensburger). Plus notes and references.

*Radical Geography: Alternative Viewpoints on Contemporary Social Issues*, Ed. by Richard Peet, 1977, 385 pp, paperback only, \$7.95, Maaroufa Press; 610 N. Fairbanks Court; Chicago, Illinois 60611. This book is a collection of essays drawn mainly from *Antipode: A Radical Journal of Geography*; P.O. Box 225, West Side Station; Worcester, Mass. 01602.

"Science and Imperialism" by Anis Alam is the feature article in the Winter 1978 issue of *Race & Class: A Journal for Black and Third World Liberation*; Institute of Race Relations; 247-9 Pentonville Road; London N1 9NG England. U.S. Mailing agent: Expeditors of the Printed Word Ltd; 527 Madison Avenue, Suite 1217; New York, New York 10022.



Karen Norberg

"The Political Economy of Health" is a special issue of the *Review of Radical Political Economics* (Vol 9, #1, Spring 1977), \$3.00. From the Union for Radical Political Economics; 41 Union Square West, Rm 901; New York, New York 10003. The eight articles make a good contribution toward a thoroughgoing Marxist critique of the health industry in this country.

*Seizing Our Bodies: The Politics of Women's Health*, Ed. by Claudia Dreifus, Vintage/Random House, 1977, 320 pp, \$4.95. A good full-spectrum collection of writings (one of them reprinted from SftP) that incorporate a feminist critique of American health care into the story of the women who are pioneers of self-knowledge and self-determination and who proudly call themselves health feminists.

Spokesman Books; Bertrand Russell House; Gamble Street; Nottingham N67 4ET; England. This British group has produced several titles that science activists will find useful . . . *Poor Health, Rich Profits: Multinational Drug Companies and the Third World*, Tom Heller, *Health in the Third World: Studies from Vietnam*, Dr. Joan McMichael, *Resources and the Environment: A Socialist Perspective*, Brown, Emerson & Stoneman, *Bureaucracy and Technocracy in the Socialist Countries*,

Serge Mallet, *Computers and Socialism*, Stephen Bodington, *Socialism and the Environment*, Ed. Ken Coates, *National Frontiers and International Scientific Co-operation*, Zhores A. Medvedev, *Neighbourhood Councils and Modern Technology*, Stephen Bodington, *Technology and the State*, John Eaton, "Consumerism" and the Ecological Crisis, Alan Roberts, and many other titles of a more general political nature.

*Farming for Profit in a Hungry World: Capital and the Crisis in Agriculture*. Authored by Michael Perelman (preface by Barry Commoner). 1977, 238 pp, \$14.00. Published by Allanheld, Osmun & Co.; 19 Brunswick Road; Montclair, New Jersey 07042. If you liked *Food First* you will definitely want to read Perelman's book. Partial contents: The myth of agricultural efficiency/ Prologue/ Energy Efficiency. Developing Agriculture for profit/ The roots of American agriculture/ Corn and the selling of the soil/ Speculation/ The industrialization of corn/ The meaning of mining/ Appendix on prices. Capital conquers the countryside/ The human dimension of technical progress/ The new feudalism/ Large and small scale farming. The Global Domain of capital/ Growing hunger in the Third World/ Sacred cows and bum steers/ The roots of impoverishment/ The Green Revolution/ The fertilizer story/ The hidden power of Third World agriculture. Myth and economics/ Myths and primitive agriculture/ The law of diminishing returns/ Blaming the people/ Conclusion/ Index. In fact, if you haven't read *Food First* you may want to read this title first.

*Astrology Disproved*, Lawrence E. Jerome, 1977, 254 pp, \$14.95, Prometheus Books; 1203 Kensington Avenue; Buffalo, New York 14215. In 1975 Prometheus Books published *Objections to Astrology* by Jerome and Bok (it's still available for \$2.95). It was made up of reprints from *The Humanist* and at the time was the most current critique of astrology. *Astrology Disproved* is a more full length study. It's the most complete, authoritative, and readable book yet written to debunk astrology.

*The Workbook*; SW Research & Information Center; P.O. Box 4524; Albuquerque, New Mexico 87106. Monthly, \$10/year. It is a fully-indexed catalog of sources of information about

environmental, social and consumer problems. It is aimed at helping people in small towns and cities across America gain access to vital information that can help them assert control over their own lives. Many of the items used in this *SftP* resources section have been "stolen" from *The Workbook*. So now we have decided to go one step further by stealing an anti-imperialist calculator joke (from Vol. II, # 12) that goes like so. "If 55,105,426 Arabs (enter this number into the calculator) fight (+) 30,187,388 Jews (enter this number and sum) for ten days (x 10) over 12 miles of desert (/12), who wins? Turn the calculator around and read the startling answer."

*Supplying Repression: U.S. Support For Authoritarian Regimes Abroad*. Michael T. Klare, 1977, 56 pp, \$ .75. Published by the Field Foundation, distributed by the Institute for Policy Studies/ Transnational Institute; 1901 Q Street, N.W.; Washington, D.C. 20009. The first fully-documented study of the export of repressive technology and methodology from the United States to dictators abroad.

*Off Our Backs*; 1724 20th Street, N.W.; Washington, D.C. 20009. Monthly, \$6/year. Subtitled, A Women's News Journal. Though, of course, *SftP* readers probably already subscribe to this fine news journal we want to make a special mention of an article by Alice Henry that is entitled "Questioning Authority: Women, Science, and Politics." It is about the meetings on sociobiology and genes and gender, held at the AAAS in mid-February.

*Energy Self-Reliance* (reprints from *Self-Reliance*), 1977, \$1.00, 16 pp, from Institute for Self Reliance; 1717 18th Street, N.W.; Washington, D.C. 20009.. Their bi-monthly newsletter *Self-Reliance* from which it is reprinted goes for \$6/year.

#### TITLES THAT CAUGHT OUR EYE

*The Home Computer Revolution*, Ted Nelson, 1977, 224 pp, paperback, \$2.00. The Distributors: 702 South Michigan; South Bend, Indiana 46618.

*Biohazard*, Michael Rogers, Alfred A. Knopf, 1977, 209 pp, \$8.95.

*Scientific Elite: Nobel Laureates in the United States*, Harriet Zuckerman, The Free Press/Macmillan, 1977, \$14.95.

*Scientists Confront Velikovsky*, Donald Goldsmith, Ed., Cornell University Press, 1977, 183 pp, \$8.95.

*Playing God: Genetic Engineering and the Manipulation of Life*, June Goodfield, Random House, 1977, 218 pp, \$8.95.

*Women's Studies Sourcebook: A Comprehensive Classified Bibliography*, Compiled by Judith D. King (3327 Campus View Apts; Allendale, Michigan 49401), 1976, 68 pp, packed with info, \$3.00, prepayment required.

*Mental and Physical Health Problems of Black Women*, Black Women's Community Development Foundation (1028 Connecticut Avenue, N.W., Suite 1020; Washington, D.C. 20036), 1975, 136 pp, large format, paperback, \$9.95.

*The Picture of Health: Environmental Sources of Disease*, Erik P. Eckholm, W.W. Norton, 1977, 256 pp, paper, \$3.95.

*Autonomous Technology: Technics-out-of-Control as a Theme in Political Thought*, Langdon Winner, MIT Press, 1977, 386 pp, \$17.50.

*Nursing Homes: A Citizen's Action Guide*, Linda Horn and Elma Griesel, Beacon Press, 1977, 190 pp, paper, \$2.95.

*Maggie Kuhn on Aging*, Edited by Dieter Hessel, Westminster Press, 1977, 140 pp, paper, \$3.95. Both of these titles were highly recommended by people at the *Grey Panther Network*; 3700 Chestnut Street; Philadelphia, Pennsylvania 19104. Quarterly, \$3.00/year.

*Marx and Engels on Ecology*, Ed. by Howard L. Parsons, Greenwood, 1977, \$16.95.

*Science Textbook Controversies and the Politics of Equal Time*, Dorothy Nelkin, MIT Press, 1977, \$12.95.

*Ethnic Medicine in the Southwest*, Edward H. Spicer, Ed., University of Arizona Press, 1977, 291 pp, \$6.95, paper.

*Technology and Social Shock*, Edward W. Lawless, Rutgers University Press, 1977, 616 pp, paper, \$6.95.

# LESBIAN HEALTH CARE: ISSUES AND LITERATURE

by Mary O'Donnell



*Eileen Whalen/Sister Courage*

Lesbians face great discrimination when seeking health care. Although this discrimination can be found in all health-related areas, it is probably most predominant in the areas of gynecology, reproduction and mental health. Most doctors view women in terms of reproduction and assume that all of us either use or need contraceptives. In most parts of the country, the only place a woman can get free gynecological care is in a birth control clinic. At the same time, the health profession does not recognize that lesbians can, and do, choose to have children. Consequently, artificial insemination is geared towards heterosexual women; to have access to sperm banks, a lesbian will often have to lie about her sexuality.

Hospital guidelines and health-insurance plans do not recognize a lesbian's lover and friends as her chosen family. For example, if a lesbian was in a health-emergency situation, her lover/partner would not be able to sign legal consent forms like a heterosexual spouse could. Of course, unmarried heterosexual couples also lack these rights, but at least they have the option of marriage.

These examples portray the heterosexual bias and nuclear-family orientation of the present U.S. health-care system. Because of the health professions' heterosexism, and because almost all of the medical and mental health professions are indoctrinated with male sexism and stereotypes, lesbian health care has been largely ignored. The medical profession is extremely lacking in knowledge of health issues that affect lesbians and that do not affect heterosexual women, and vice versa. This ignorance promotes and perpetuates myths about lesbians. Heterosexism is the assumption of the superiority and exclusiveness of heterosexual relationships and is one of the cornerstones of male supremacy and sexism. Heterosexual relationships are seen as the norm and homosexuality is either ignored or is seen as deviant. Heterosexism is inextricably tied with homophobia which is defined as the fear of same-sex intimacy. Homophobia also involves the extreme rage, as well as the fear, that many people feel towards homosexuals. The Gay Public Health Workers, a Philadelphia-based group, wrote in 1975:

Homophobia expresses itself in the health field in many ways. The delivery of good health care is adversely affected because homophobia encourages or justifies such practices as: verbal and nonverbal language which alienates gay people and thus interferes with their giving complete histories, their cooperating fully in treatment plans and their accepting preventive services; omission of necessary diagnostic tests for some forms of sexually transmitted diseases; use of electroconvulsive and aversion "therapy" to "cure" homosexuality; denying critically ill patients in intensive care units the emotional support of visits from gay lovers and close friends; overlooking maintenance and outreach methods appropriate to gay people; trying to "treat" homosexuality instead of alcoholism or drug addiction in a gay person with a chemical-dependency problem; basing diagnosis or therapy on the assumption of opposite-sex sexual relations; [and] provoking emotional stress and anguish.(1)

These examples indicate how a woman's overt or suspected lesbianism is often an interfering factor in receiving adequate health care.

Under these conditions a lesbian is forced to decide whether to come out (identify herself as a lesbian) to her health worker or therapist. This decision presents a double-bind. If she chooses to come out to a doctor, she

---

**Heterosexism is the assumption of the superiority and exclusiveness of heterosexual relationships and is one of the cornerstones of male supremacy and sexism.**

---

is often subjected to attempts to humiliate her, to accusations of perversion, or to suggestions that she should see a psychiatrist. Doctors and therapists will often indulge in asking voyeuristic questions about the nature of a lesbian's sexual activities.

If a lesbian chooses not to come out, the assumption is that she is heterosexual. This assumption may, at times, contribute to the misdiagnosis of her condition based on a lack of information. For example, a lesbian rushed to the emergency room with acute abdominal pain may be diagnosed as either having appendicitis or as having a ruptured ectopic pregnancy, which is pregnancy implanted in the fallopian tube. Knowledge of her lesbianism could, in most cases, disqualify the latter option and could speed up treatment on the appendicitis.

A lesbian who is not out to her doctor is usually asked about her birth-control method and is cornered into lying about her personal life. In this situation, she will not be able to ask questions leading to a better understanding of her specific health needs.

Information and answers to questions about lesbian health needs are scarce due to our society's historic bias against homosexuality and women. Health care in

---

*Mary O'Donnell, a three-year member of the Santa Cruz (California) Women's Health Collective, has been researching lesbian health issues for the past year. The Women's Health Collective is a socialist feminist organization of thirty women who maintain the Women's Health Center (WHC). O'Donnell's work at the WHC has included health education and community outreach, pamphlet distribution and lab work for gynecological medical services. She is active in gay rights groups and is also a member of a women's softball team and judo club.*

---

Copyright 1978 by the Santa Cruz Women's Health Collective. Lesbians, women's health centers, and movement groups have permission to copy.

this country is based on a profit motive. In such a system, it is no wonder that there is inadequate health care for lesbians as well as for women in general, working class people, ethnic and minority groups, and older people.

Health professionals and consumers alike have begun to give more attention to sociopolitical perspectives on health and health-care services; however, the perspective that is now being developed is heterosexual in nature. The medical and mental-health professions have little understanding of the societal pressures that affect lesbians. Stress from living in a heterosexist society can be a cause of health problems, especially emotional ones. In most cases, a lesbian's visit to a doctor or therapist will exaggerate, rather than alleviate the stress that she experiences as part of her daily life. Lesbians have begun to write about what it is like to be a lesbian in this society, but, as yet, the link between these perspectives and the health care that lesbians receive is only very tentative.



The result of heterosexist and inadequate health care is that often lesbians decide to not seek preventive or even primary health care. Women's health centers provide a positive alternative for lesbians although only a small percentage of lesbians, and an even smaller percentage of their health needs, can be met by these centers. There are many lesbians involved in working with the women's health movement. Frances Hornstein, a lesbian feminist working at the Los Angeles Feminist Women's Health Center, wrote in her pamphlet, *Lesbian Health Care*(2):

---

## The myth that the women's health movement is for heterosexual women must be destroyed . . .

---

The myth that the women's health movement is for heterosexual women must be destroyed. . . The idea [for a women's health movement] was in both the heads of straight women as well as in the heads of lesbians. There was the same exclusion of the needs of lesbians in the early women's health movement as there was in the women's movement in general . . . [Lesbian involvement in the women's health movement] is important both in an immediate, practical sense as well as in a wider political sense. It was true that the early women's movement dealt with abortion and contraception. It is naive to think that those issues are irrelevant to us, as lesbians. They are vital to all of us who are feminists in light of the use of women's bodies by men for their purposes — from rape to population control, two issues that affect every one of us, regardless of our sexuality . . . The assumption that all lesbians are young, unmarried, childless and healthy is simply incorrect. We have vaginal infections, we have painful menstruation; we have symptoms of menopause . . . Some of us choose to have children and some of us are still forced to marry and have children. We need women's medicine as much as any other woman.

### Process of Reviewing the Literature

I facilitated a Lesbian Health Issues discussion section for the Female Physiology and Gynecology class at the University of California at Santa Cruz in Spring of 1977. The women in the group compiled and annotated a twenty-two piece bibliography on lesbian health-related articles, books and pamphlets obtained by writing to numerous women's health centers and lesbian groups in the U.S. Each group or center that responded to our letters knew of only a small fraction of the available literature. The bibliography (3) was printed and distributed by the Santa Cruz Women's Health Collective, of which I am a member.

The literature that we found discussed health issues that affect lesbians gynecologically, emotionally and in regard to reproduction. When reviewing each piece of literature, the Lesbian Health Issues group took into consideration who it was written by and for, and the extent to which, if at all, the author discussed the health situation in a sociopolitical context.

I will discuss the literature we found, more recent literature and other issues in gynecology, reproduction and mental health.

In doing this research, I was assisted by several lesbians, some of whom are health workers or therapists. Also, this article would not exist without the assistance and support of the women in the Santa Cruz Women's Health Collective.

### Gynecology

Considerably more is known about lesbian gynecological health than is available in written form. This knowledge is shared by lesbians involved in the women's health movement and probably by a few feminist health practitioners. This by no means implies that what is known is complete, nor that the literature that is available is unimportant. However, much more in-depth information and research is necessary on this topic.

The literature which is available to us now has been, for the most part, written by lesbians working in the women's health movement. This literature provides a good starting point and is often written within a feminist framework. However, the sources are often repetitive in that they draw from each other. There is a necessity for funding to be allocated to lesbian researchers to pursue this area further.

There is also some information on lesbian gynecology in the traditional gynecological medical textbooks; however, it takes quite a lot of searching and reading between the heterosexism to find accurate information.

Three sources on specific lesbian gynecological health that we found are: *Lesbian Health Care* (2) by Frances Hornstein, a nine page booklet; "Information on V.D. for Gay Women and Men" by Julian Bamford in *After You're Out* (4); and *Health Care for Lesbians* (5) by the Chico (California) Feminist Women's Health Center, a five page fact sheet. These sources state that there are some gynecological health issues that lesbians share with heterosexual women, and some that seem to affect lesbians rarely, if at all. Hornstein (2) expands on this last category by saying that:

In general, women who do not have sexual relations with men have far fewer problems with maintaining the good health of our genitals, uterus, fallopian tubes and, for that matter, our whole bodies . . . V.D. in lesbians is very rare. Also, in general, we will find that we [lesbians] are less often bothered with vaginal infections than women who have sexual intercourse with men . . . Heterosexuality is a serious health hazard for women at this point in time. Because we don't have to use contraceptives (most of which are experimental and have many dangerous side effects)

we are taking a lot fewer risks with our health than women who must be content with inadequate contraception.

Most of the literature includes, to a varying extent, information on vaginal infections (yeast, bacteria, and trichomonas), gonorrhea, syphilis, venereal warts, herpes, crabs (pubic lice) and scabies. Symptoms, treatments, transmission and some prevention are discussed. Most of the information comes from the sharing of experiences in lesbian self-help groups and observations at women's health centers. There is no mention of the incidence of pelvic inflammatory disease (PID) or urinary tract infections in lesbians. Nor is there any discussion of infections transmitted through the bowel, such as hepatitis, all parasites including amoeba, and bacterial and viral diarrheas which can be a problem for anyone who has oral sex. More in-depth and lesbian-specific information on genital herpes is also necessary. In future presentations on the prevention and treatment of gynecological problems, more information on home remedies and self-health care as an alternative to doctor-dependent diagnosis and chemical treatment would be valuable.

Concerning V.D., the sources state that syphilis and gonorrhea seem to be almost nonexistent in communities of exclusively lesbian women (2,4,5). The gonorrhea bacteria can thrive in the cervix, rectum or throat. In theory, if an infected woman has an exceptionally heavy discharge from her vagina (which would provide an environment capable of keeping the bacteria alive outside of the body for a longer period of time than is normal), the bacteria might be passed in sufficient quantity from a finger or tongue to her partner's cervix or throat. In actuality, however, this seems to be very rare.

Lesbians do get vaginal infections, though perhaps less frequently than heterosexual women. Hornstein suggests that this lowered probability may be due to the

way in which certain birth-control methods may increase a woman's susceptibility to vaginal infections. She adds that the higher incidence in heterosexual women may also be due to the lack of "male hygiene" which could introduce harmful bacteria during coitus. Trichomonas, bacterial infections and yeast can be passed from woman to woman on fingers that are moist with vaginal secretions (2,5). Lesbians, like any other women, can develop a yeast or bacterial infection without any contact with another person. The reasons for this may be related to stress, poor general health or poor hygiene habits.

---

If the heterosexism of most doctors makes it a personal risk for a lesbian to come out, or, if out, to talk frankly about her lovemaking styles, then knowledge of how vaginal infections, V.D., or other illnesses are passed from woman to woman will not become known.

---

Certain aspects of lesbian sexuality may relate to gynecological health care. If the heterosexism of most doctors makes it a personal risk for a lesbian to come out, or, if out, to talk frankly about her lovemaking styles, then knowledge of how vaginal infections, V.D., or other illnesses are passed from woman to woman will not become known.

Hornstein (2) discusses cervical cancer in relation to lesbians:

There is growing evidence that women who do not have sexual contact with men have less chance of developing cervical cancer than women who have

---

## SHARING MORE THAN LOVE

©1976 by ROBERTA GREGORY



sexual intercourse with men. There are studies that show that certain women have less incidence of cervical cancer than others. Cervical cancer in nuns is almost nonexistent and Jewish women have had a much lower rate of cervical cancer (supposedly due to the fact that Jewish men are circumcized and carry fewer bacteria under the foreskin of the penis). Women who are more likely to develop cervical cancer are women who have had sexual intercourse from an early age and the risk seems to increase for a woman who has had many [male] sexual partners.

Hornstein did not reference the above information; however, references 6-8 mention or discuss the lower incidence of cervical cancer in nuns and reference 8 discusses the incidence in Jewish women. Kessler (8) discusses the evidence on the possible role of male coital partners in cervical cancer. Rutledge *et al.* (9) state that some categories of women with a higher incidence of cervical cancer are those who married at an early age, those who had coitus at an early age, those who have had a higher number of births, and those who are prostitutes. An extrapolation of these studies may imply that lesbians would have a lower incidence of cervical cancer. However, direct studies of lesbians are needed to verify this implication.

Breast cancer may be a health concern for lesbians and any woman who chooses not to have children. Studies have shown that there is a higher incidence of breast cancer in women who have not had children and in women who have had their first birth after age 30 (10, 11).

### Medical Research and Books on Lesbians and Gynecology

Gynecological medical books are the primary resources of information for the physician and teaching tools for medical students. What these books have to say about lesbians reflect the treatment lesbians are likely to receive. For example, the authors of *A New Look at Vulvo-vaginitis* (12), put forth a negative view

of lesbians. They partially ascribe the increase in V.D. to "the great number of demonstrations and protests for acceptance of male and female homosexuality." I have yet to see any documentation of how demonstrations can spread V.D., while it is a fact that the incidence of V.D. is lower among lesbians than among the general population (2). The authors' statement reflects their prejudice as well as their inaccurate assumption that health issues that affect gay men also affect lesbians. Here, as in most medical texts, one must go through this heterosexual and inaccurate information to glean out tidbits of information relevant to lesbians. For instance, in *A New Look at Vulvo-vaginitis* it is mentioned that trichomonas can be passed vulva to vulva. Unfortunately, when, as in this case, inaccurate and accurate information are mixed together, the differentiation between them can be made only by people who already know the facts. In other words, such books will often not be useful to many doctors or lesbians.

There are a few relatively liberal medical texts such as *Gynecology and Obstetrics: Health Care of Women* (13) which essentially describes lesbians as healthy well-adjusted human beings. This book deals with women as whole human beings whose health is integrally related to their social roles and to the pressures on them in a changing society. The text stresses the need for the physician to perceive, accept, and relate to the variety of roles which modern women choose, rather than continuously reinforcing the traditional wife-mother, dependent person role. Even with this attitude, lesbians are mentioned in only about 0.1% of the book which contrasts with the estimate that lesbians comprise 10-12% of the female population. In the remaining percentage of the text, the patient is assumed to be heterosexual. There is no mention of how likely lesbians are to transmit various communicable diseases.

The medical profession has conducted a small number of studies on lesbians and health care. These studies have been reported by Lois West, a lesbian involved in the women's movement, in her article "Lesbian Related Medical Research" (14).



West used the *Index Medicus*, a subject list of published articles in medical literature, to find the research. She notes that "the way lesbians are viewed by the medical establishment is reflected in the difficulty of finding lesbian-related literature in the *Index Medicus*." Previous to 1968, the *Index Medicus* had no mention of lesbians in the subject headings at all. Now the subject heading of "lesbianism" is followed by "see under homosexuality." West found that most of the articles cited under homosexuality were either about the causes of and cures for homosexuality or about venereal diseases related to male homosexuality.

The articles she found written between 1965 and 1975 that are specifically concerned with lesbians are titled: "Physique and physical health of female homosexuals;" "Homosexual women: an endocrine and psychological study;" "Endocrine functions in male and female homosexuals;" and "Hormonal induction and prevention of female homosexuality" (a study of rat behavior). West states that these articles are problem-oriented and do not discuss gynecological problems that affect heterosexual women and do not affect lesbians, and vice versa.

---

The larger amount of medical research about male homosexuals as compared with that about lesbians reflects this society's attitude that women and their activities are less important than those of men . . .

---

The larger amount of medical research about male homosexuals as compared with that about lesbians reflects this society's attitude that women and their activities are less important than those of men and are, thus, less worthy of research by men. Extrapolating the results of studies on male homosexuals to lesbians has created erroneous information in both the medical and mental health professions.

Prejudiced attitudes against lesbians have resulted in a scarcity of information on lesbian gynecological health. Not wanting to deal with the heterosexism of most gynecologists, some lesbians do not seek out health services, and those who do, often do not identify themselves as lesbians. This enforced invisibility creates a downward spiral in which the negative attitudes towards lesbians promote further lack of knowledge, which then creates inadequate health care.

### Reproduction

Related to gynecology, yet distinct from it, is the issue of reproduction, on which very little has been written. There is a prevalent assumption that lesbians do not have children or that lesbians who do have children had them before they came out. Actually, a significant number of lesbians have children, possibly as many as one-third (15).

Lesbians who want to have children can either artificially inseminate themselves or can engage in coitus with a man. Access to sperm banks requires the assistance of a medical doctor, and usually a lesbian will have to lie about her sexuality and lifestyle to obtain this service. Some lesbians have begun experimenting with "home methods" of artificial insemination using the sperm of a willing donor collected in a condom and transferred to the vagina. The transferring process may involve the use of a diaphragm or any pipette-like object.

If you want to experiment with artificial insemination, remember that daylight irreparably damages the sperm and that it must be used very soon after collecting unless you are able to store it via a sophisticated method of freezing.(16)

There is very little information available on artificial insemination other than that which I have mentioned above. Nor is there literature that deals with the harassment lesbian mothers and their children receive from the medical profession, such as during visits to pediatricians.



In "Radical Reproduction: X without Y" (16), Laurel Galana discusses a method of sex determination previous to conception and potential future methods of female reproduction without men, such as parthenogenesis and cloning. Cloning is the transplantation of the genetic material from one body cell into an egg cell which has had its genetic material removed. This process in frogs has produced a frog "offspring" genetically identical to the frog that donated one of its body cells. Parthenogenesis is female asexual reproduction, that is, the development of the egg without the sperm, which will always result in a female offspring. However hypothetical parthenogenesis is for humans, it is a natural form of reproduction in a worm-like animal called a rotifer.(17) Galana cites the work of two researchers who in 1940 succeeded in bringing one rabbit (out of 200 tested) to fullterm by means of parthenogenesis. Appended to Galana's article is a list of sources that will be valuable to others pursuing this field.

Robert Francoeur in *Utopian Motherhood: New Trends in Human Reproduction*(18) also discusses many of these potential reproductive methods. However, because of his nonfeminist and apolitical consciousness, this book is relevant to lesbians only as a reference source.

In view of the fact that most of the research on reproduction is being done by men, some of whom are blatant about their motives to produce only male children, Galana says to all women:

Whatever our feelings, whether we are morally repelled by this kind of tampering with nature or sure we never want children anyway, or are content to have them by the usual method, none of us can afford to ignore the potential (for good and/or evil) which is developing in the scientific laboratories. We can only hope that women will see that this is a new but crucial political battleground — one we can't afford to walk away from.(16)

## Mental Health

The close relation of mental and physical health is a concept that is rapidly becoming more accepted in our society, although the actual widespread use of this concept in the medical or psychological health professions is still quite a ways off.

The search for literature on lesbians and therapy was not a primary focus of the Lesbian Health Issues group, though we did review some of the available literature. There are several varying degrees to which the mental health profession manifests its heterosexism and homophobia towards lesbians (and gay men):

**Persecution:** Lesbianism is viewed as repulsive and as a sickness in itself; to be cured means to become heterosexual. Treatments to change homosexual behavior have included, and to some extent still include, lobotomies, electroshock, aversion and hormonal "therapy," and behavior modification. Many therapists still assume that a woman's lesbianism is the root cause, or the result of, her emotional problems. Since mental health professionals are often the spokespeople who determine "one's fitness" in society, judgment of lesbians by therapists can lead to discrimination, especially in employment and child custody.

**Tolerance:** Tolerance is the gift of the superior to the inferior. Lesbianism is viewed as infantile and as a stage that will be grown out of. Heterosexuality is considered more mature. Another aspect of tolerance is that lesbians are pitied because they are not "normal."

**Acceptance:** Lesbian struggles and identity are made invisible. "To me you're not a lesbian, you're just a person." "It's your business who you sleep with." This is the attitude of the so-called liberal therapists who do not see the political significance of lesbianism nor do they understand the cultural importance of a lesbian lifestyle.



---

It has not been a priority for the mental health profession to recognize and understand the stresses that lesbians experience . . .

---

### Stress

It has not been a priority for the mental health profession to recognize and understand the stresses that lesbians experience which are related to living in a society that condemns and misunderstands homosexuality. It is even questionable, at this time, if nonlesbian therapists, no matter how sincere and informed, can fully support and understand lesbian clients, and validate their strength in surviving.

One source of stress that affects lesbians is the internalization of heterosexism and homophobia. To identify oneself as homosexual is to immediately identify with a group that is hated and despised by all racial, religious, and ethnic groups — even one's own. Any internalization of this hatred affects a lesbian's self-image and can often result in feelings of guilt. Daily social ostracism also occurs. Visible lesbians are treated as outcasts or queers. They are ignored, fantasized about, and played with. Lesbians are subject to verbal and physical harassment. Closeted lesbians live in fear of being found out. A lesbian's family may be a source of stress for her as coming out to one's family can often mean risking anger, pain, or exile. Drifting apart from one's family may be the result of not coming out. The process of redefining relationships and roles with one's lover is often a stressful as well as a liberating process. Having seen the inadequacy of the male-female (butch-femme) role models, many lesbians are struggling to create new, intimate, role models for relationships.

Lesbians may encounter discrimination in employment. A woman can be legally fired from her job in some cases for being a lesbian, and in others she may be

harassed so intensely that she will be forced to quit. A handbook published by the U.S. Department of Labor in 1971 states that in 42 states, homosexuals cannot legally pursue the following licensed professions (this is a partial listing): accountant, attorney, beautician, chiropractor, electrician, firefighter, insurance agent, lawyer, pharmacist, plumber, registered nurse, state trooper, taxicab driver, and veterinarian.

For most lesbians their job is their only source of income. In our society it is assumed that all women are married or are otherwise dependent on a man for financial support. This assumption is used to justify the secondary position of the working woman and to justify women's lower pay and last-to-hire, first-to-fire status. Furthermore, this assumption puts lesbians and single women in a stressful, tenuous financial and career situation.

The issue of lesbian motherhood and lesbianism among adolescents also represents sources of stress. As mentioned earlier a significant number of lesbians have children, possibly as many as one-third. Many custody cases have ruled against lesbians as being "unfit" mothers, or the authorities have made lesbians choose between their lovers and their children. An adolescent's lesbianism is often dismissed by therapists, parents, and educators as a "stage" which will be grown out of. Not only is this attitude unsupportive of the adolescent's present feelings but it can cause her much stress when she reaches adulthood and has not "outgrown that stage." Also, therapy for adolescents is usually contingent on parental consent; most parents won't let their teenager see a lesbian therapist.

To summarize on the stresses that lesbians experience in this society:

Can you understand that the pain a woman experiences is not inherent in her lesbian relationship; the relationship itself is seen as beautiful and supportive. The sham, having to lie, the constant fear of disclosure followed by rejection, the alienation and feeling that no one understands comprise the source of pain(15).



And in spite of this pain, for lesbians and gay men:

It is a phenomenal act of courage and self assertion to accept and own a part of oneself that society says is "sick" — and you know inside it is not, and you are not, and you are the *only* authority for that decision(19).

### Gay Health Workers

The health field, and society in general, suffer a loss when heterosexism and homophobia restricts or eliminates opportunities of gay people to make their optimal contributions as health workers. Escamilla-Mondanaro(15) says the following about lesbian therapists, but her passage can be applied equally as powerfully to lesbian doctors or health practitioners:

Lesbian therapists must come out! "Every time you keep your mouth shut you make life that much harder for every lesbian in this country. Our freedom is worth your losing your jobs and your friends" (Brown, 1972, ref. 20) . . . There is only one way for mental health centers and schools to demonstrate their good faith to the lesbian community, and that is to hire lesbian therapists and faculty . . . Lesbians can facilitate the hiring of lesbian therapists by sitting on the advisory boards to community mental health centers. The lesbian community must evaluate all services offered to lesbians, and advise women as to the sincerity and efficacy of these programs.

### Solutions for the Future

Working towards solutions to the lack of adequate health care for lesbians can be focused in at least two directions:

1. Pressuring the health professions to educate themselves on the validity of lesbianism as a lifestyle. It is important for every doctor or psychologist to know

the facts about lesbianism that are relevant to her or his specialization. As mentioned earlier, there is a necessity for funding to be allocated to lesbian researchers so that more current and in-depth statistics can be compiled on lesbian health. It is also necessary for pressure to be put on professional medical, public health, and mental health schools to admit open lesbians into their training programs.

2. Developing and participating in alternative lesbian, feminist, or socialist/feminist health centers and counseling centers. This is important for creating environments where lesbians will feel comfortable and validated. Such centers are also important in their employment of lesbian health workers or therapists.

Both of these directions require self-education about lesbians' specific health needs. Both also require a political analysis and framework in which to see that changes in the medical profession's heterosexism will come about only with changes in our society as a whole. With such an analysis, lesbians can see that their experiences with the health care system are not isolated and can organize for change.

Education is one of our most valuable tools. Myths about lesbians thrive on ignorance, and prejudice has its basis in the misinterpretation of facts. In the realm of health care, it is important for lesbians to re-direct the interpretation and teaching of science, medicine, and psychology. Biased interpretation of research continues to perpetuate notions of female inferiority and of homosexual perversion. Even progressive university classes on female health care continue to teach about V.D. and reproduction only in terms of heterosexuality. Science can be a tool for us to better understand our selves and the universe. As it is used now, it is a tool to perpetuate the power imbalances and oppressive ideologies of our culture.

Lesbian-related research and constructive health care will increase with the growing number of lesbians who are proud of their sexuality and lesbian feminists who see lesbianism as a political as well as sexual identification.□



## ANNOTATED LITERATURE LIST ON LESBIAN HEALTH

### Lesbians and Therapy: Experiences and Critiques

Josette Escamilla-Mondanaro's "Lesbians and Therapy" and Barbara Sang's "Psychotherapy with Lesbians: Some Observations and Tentative Generalizations," both in *Psychotherapy for Women: Treatment Toward Equality*(16) provide excellent consciousness-raising material on the needs of lesbian women who seek therapy. Both authors are therapists and lesbians. The articles are valuable and readable for professionals and non-professionals alike.

"Lesbians and the Health Care System"(17) by the Radicalesbians Health Collective is a very strong statement about the mistreatment of lesbians by therapists. The article relates the personal experiences of seven lesbians in therapy.

"The Psychoanalysis of Edward the Dyke"(18) by Judy Grahn — a humorous and biting sarcastic short story.

"The-Rapist: Lesbians and Psychiatry" — a short passage in the widely available *Our Bodies, Ourselves*(21).

Karin Wandrei, a lesbian feminist, conducted a constructive study, "Lesbians in Therapy"(22) in which she reports on how lesbians perceive their experiences in therapy.

In "Oppression is Big Business: Scrutinizing Gay Therapy" (in 23), Karla Jay discusses the relationship between lesbian therapist and their clients. She points out that although lesbians are rightfully wary of the traditional therapists, they cannot assume that all gay therapists will be acceptable. She offers a list of criteria for choosing a therapist and encourages clients to go into therapy with an informed and critical attitude.

Don Clark, in *Loving Someone Gay*(24), discusses the role of psychotherapists and counselors in "helping someone gay." His twelve therapeutic guidelines for mental health professionals working with gay clients are very valuable.

### Psychology of Lesbianism

*Love Between Women*(25) by Charlotte Wolff offers a historical presentation of the early psychoanalytic theories on lesbianism. Wolff partially aligns herself with the belief that the essence of lesbianism is emotional incest with the mother. Although she has some understanding of social pressures confronting lesbians, much of her theory is misinformed and outdated.

Although the bulk of Phyllis Chesler's book, *Women and Madness*(26), is highly valued by feminists and therapists, her chapter on lesbians is shallow and disappointing. A constructive aspect of this chapter is that Chesler discusses how many clinician-researchers have confused lesbianism with male homosexuality.

"Psychological Test Data on Female Homosexuals: A Review of the Literature"(27) by B. Riess *et al.* is a critical and comparative academic review of the studies before 1974 on lesbians. Much of the data is contradictory but the evidence indicates that lesbians "seem to differ . . . in psychodynamics" from male homosexuals and that lesbians have no more psychopathology than heterosexual female controls.

One important sub-category of lesbian psychology is that of third world lesbians and their relationship to their cultures. An insightful article on this topic is "The Puerto Rican Lesbian and Puerto Rican Community" (28) by N. Hidalgo and E. Christensen.

(continued on next page)



## Psychology of Homosexuality

The literature mentioned in this section does not specifically deal with lesbians, but rather with gay people in general, sometimes with an emphasis on gay men. For this reason, lesbians, and therapists working with lesbians, will find that the literature varies in value and relevancy.

"Far From Illness: Homosexuals may be Healthier than Straights"(29) was written by Mark Friedman, a gay psychologist. Friedman discusses the changes taking place in the traditional views held by psychologists towards homosexuality. He includes studies that help show that homosexuality is not only normal, but that in some ways, gays may actually function better than non-gays. Friedman also wrote a valuable article on "Homophobia"(30), and a book, *Homosexuality and Psychological Functioning*(31).

In *Society and the Healthy Homosexual*(32), George Weinberg discusses, among other topics, gay people and therapy, coming out to parents, and what his idea of a healthy homosexual is. Weinberg presents aspects of the heterosexism in the mental health system. However, he believes that lesbians do not have as much difficulty in surviving as gay men and he deals very little with the problems of traditional sex roles which are inherent in heterosexism.

The *Journal of Homosexuality*(33) is written for mental health and behavioral science professionals. It is very academic and has the most recent research. The *Homosexual Counseling Journal*(34) is geared to counseling and therapy issues.

In *Etiological and Treatment Literature on Homosexuality*(35), Ralph Blair points out that no one knows the causes of homosexuality, though obviously, many people have tried to find reasons and causes. To fairly question the cause of homosexuality, the cause of heterosexuality must equally be questioned.

## Lesbian Adolescents

*Growing Up Gay*(36) by Youth Liberation presents a dozen articles about the experience of being young and gay, including accepting one's own gayness, and coming out and talking with parents. Extensive resources are appended.

*High School Women's Liberation*(36) by Youth Liberation includes articles on lesbianism.

*Learning About Sex*(37) by Gary Kelly is a standard, school textbook that takes a positive view of homosexuality.

Mondanaro(15) briefly summarizes some of the issues involved for lesbian adolescents from a therapist's viewpoint.

*Parents of Gays* by Betty Fairchild(38) and "A Psychiatrist Answers Teen Questions About Homosexuality"(39), by Robert Gould in *Seventeen* magazine also relate to this topic.

## Lesbian Mothers

*By Her Own Admission: A Lesbian Mother's Fight to Keep her Son*(40), by Gifford Gibson.

"Lesbian Mother" by Jeanne Perreault in *After You're Out*(41).

The bibliographic information for the following articles is listed in *A Gay Bibliography*(42):

R.A. Basile, "Lesbian Mothers I and II."

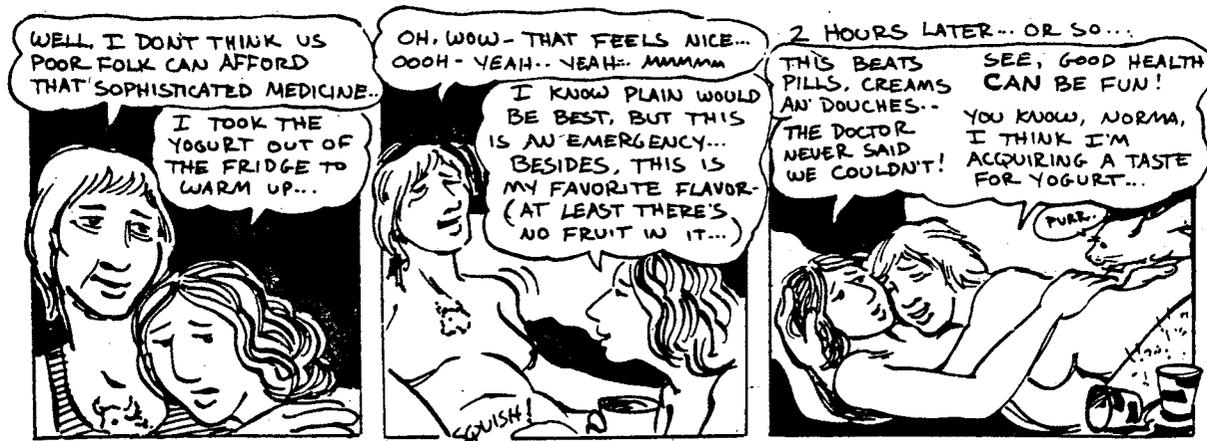
Carole Klein, "Homosexual Parents."

"The Avowed Lesbian Mother and Her Right to Child Custody: A Constitutional Challenge That can no Longer be Denied," in the *San Diego Law Review*.

Nan Hunter and Nancy Polikoff, "Custody Rights of Lesbian Mothers: Legal Theory and Litigation Strategy."

Dolores Klaich, "Parents Who Are Gay."

Del Martin and Phyllis Lyon, "Lesbian Mothers." □



## REFERENCES

1. Gay Public Health Workers (1975). "Heterosexuality: Can It Be Cured?" Available from Gay Public Health Workers, 206 N. 35th St., Philadelphia, PA, 19104.
2. Hornstein, Frances (1973). *Lesbian Health Care*. Available from Feminist Women's Health Center, 1112 Crenshaw, Los Angeles, CA, 90019.
3. Santa Cruz Women's Health Collective (1977). *Lesbian Health Issues* (annotated and unannotated forms available). Available from Santa Cruz Women's Health Center, 250 Locust St., Santa Cruz, CA, 95060.
4. Bamford, Julian (1975). "Information on VD for Gay Women and Men." In: *After You're Out: Personal Experiences of Gay Men and Lesbian Women* (1975), ed. by Karla Jay and Allen Young, Links (Quick Fox). Also available in pamphlet from the Gay Community Services Center, 1614 Wilshire Blvd., Los Angeles, CA, 90017.
5. Lesbian Self-Help Group. *Health Care for Lesbians*. Available from the Chico Feminist Women's Health Center, 330 Flume St., Chico, CA, 95926.
6. Fraumeni, J.F. et al. (1969). "Cancer Mortality Among Nuns." *Journal of National Cancer Institute*. Vol. 42, p. 455.
7. Towne, J.E. (1955). "Carcinoma of the Cervix in Nulliparous and Celibate Women." *American Journal of Obstetrics and Gynecology*, Vol. 68, p. 606.
8. Kessler, Irving I. (1976). "Human Cancer as a Venereal Disease." *Cancer Research*. Vol. 36, p. 783.
9. Rutledge, F. et al. (1976). *Gynecologic Oncology*. John Wiley & Sons, Inc.
10. Baker, R. Robinson, ed. (1977). *Current Trends in the Management of Breast Cancer*. Johns Hopkins University Press.
11. MacMahon, Brian et al. (1970). "Age at First Birth and Breast Cancer Risk." *Bulletin of World Health Organization*. Vol. 43, p. 209.
12. Cisley, L.J. and S.C. Kasdon (1971). *A New Look at Vulvovaginitis*. Searle & Co., Medical Dept., Box 5110, Chicago, Ill., 60680.
13. Romney, S. et al. (1975). *Gynecology and Obstetrics: The Health Care of Women*. McGraw-Hill.
14. West, Lois. *Lesbian-Related Medical Research*. Available from Women's Community Health, 137 Hampshire St., Cambridge, MA, 02139.
15. Escamilla-Mondanaro, Josette (1977). "Lesbians and Therapy." In: *Psychotherapy for Women*, ed. by Edna Rawlings and Dianne Carter. Charles C. Thomas, Publisher. Also found in *Issues in Radical Therapy*, Vol. 3, No. 3, Summer 1975.
16. Galana, Laurel (1975). "Radical Reproduction: X without Y," in: *The Lesbian Reader*, ed. by L. Galana and G. Covina. Amazon Press, 395 60th St., Oakland, CA, 94618.
17. Communications Research Machine, Inc. (1972). *Biology Today*. J.H. Painter, Jr., Publisher, page 771.
18. Francoeur, Robert (1970). *Utopian Motherhood—New Trends in Human Reproduction*. Doubleday.
19. Meyer, Sybil (1977). Creative Arts Therapist. Personal communication, Santa Cruz, California.
20. Brown, Rita M. (1972). "Take a Lesbian to Lunch," In: *Out of the Closets: Voices of Gay Liberation*. Douglas-Links (Quick Fox).
21. Abbott, Sidney and Barbara Love (1972). *Sappho Was a Right-On Woman: A Liberated View of Lesbianism*. Stein & Day.
22. Altman, Dennis (1971). *Homosexuality: Oppression and Liberation*. Avon Books.
23. Jay, Karla and Allen Young, eds. (1975). *After You're Out: Personal Experiences of Gay Men and Lesbian Women*. Links (Quick Fox).
24. Clark, Don (1977). *Loving Someone Gay*. Celestial Arts, 231 Adrian Rd., Millbrae, CA, 94030.
25. Wolff, Charlotte (1971). *Love Between Women*. Harper & Row.
26. Chesler, Phyllis (1972). *Women and Madness*. Avon Books.
27. Riess, B. et al. (1974). "Psychological Test Data on Female Homosexuals: A Review of the Literature." *Journal of Homosexuality*, Vol. 1, No. 1. Haworth Press, 174 Fifth Ave., New York, NY, 10010.
28. Hildalgo, H. and E. Christensen (1976). "The Puerto Rican Lesbian and the Puerto Rican Community." *Journal of Homosexuality*, Vol. 2, No. 2, Winter 1976-77. Haworth Press, 174 Fifth Ave., New York, NY, 10010.
29. Freedman, Mark (1975). "Far From Illness: Homosexuals May be Healthier Than Straights." *Psychology Today*, March 1975.
30. Freedman, Mark (1976). "Homophobia." *Blueboy*, Vol. V, April 1976. Also available from National Gay Task Force, Rm. 506, 80 Fifth Ave., New York, NY, 10011.
31. Freedman, Mark (1971). *Homosexuality and Psychological Functioning*. Brooks-Cole.
32. Weinberg, George (1972). *Society and the Healthy Homosexual*. St. Martin's.
33. *Journal of Homosexuality*. Haworth Press, 174 Fifth Ave., New York, NY, 10010.
34. *Homosexual Counseling Journal*. 30 E. 60th., New York, NY, 10022.
35. Blair, Ralph (1972). *Etiological and Treatment Literature on Homosexuality*. The Otherwise Monograph Service. The Homosexual Community Counseling Center, Inc., 30 East 60th St., New York, NY, 10022.
36. Youth Liberation. *Growing Up Gay and High School Women's Liberation*. Youth Liberation, 2007 Washtenaw Ave., Ann Arbor, Michigan, 48104.
37. Kelly, Gary F. (1977). *Learning About Sex* (revised edition). Barron's Educational Service, 113 Crossways Park Dr., Woodbury, NY, 11797.
38. Fairchild, Betty (1975). *Parents of Gays*. Lambda Rising, 1724 20th NW, Washington, DC, 20009.
39. Gould, Robert (1977). "A Psychiatrist Answers Teen Questions About Homosexuality." *Seventeen*, September 1977.
40. Gibson, Gifford Guy (1977). *By Her Own Admission: A Lesbian Mother's Fight to Keep Her Son*. Doubleday.
41. Perreault, Jeanne (1975). "Lesbian Mother," In: *After You're Out: Personal Experiences of Gay Men and Lesbian Women*, ed. by Karla Jay and Allen Young, Links (Quick Fox).
42. Task Force on Gay Liberation (1975). *A Gay Bibliography*. Task Force on Gay Liberation, American Library Association, Box 2383, Philadelphia, PA, 19103.

We'd like to thank Roberta Gregory for the use of the strip "Sharing More Than Love." The strip is an excerpt from Dynamite Damsels, a women's comic book published by the artist and available for \$1 from Roberta Gregory, PO Box 4192, Long Beach, CA 90804.

Editorial Note: Mary O'Donnell wants to mention that the use of flavored yogurt, as described in this comic strip, is only a literary liberty and definitely not recommended in actual practice. Use only plain, unflavored, unsweetened yogurt, please.

# The False Promise: Professionalism in

## *Part I of a Two-Part Article*

### INTRODUCTION

We're a group of licensed practical nurses (LPNs) and registered nurses (RNs) who have been meeting for over two years to discuss conditions and working relationships in several hospitals in the Boston area. One thing we felt it was important to talk about was the issue of "professionalism", which has continued to crop up in our training, in nursing journals, and at work. Although most nurses consider themselves professionals, we found that this means a lot of different things to different people. To the majority of nurses professionalism stands for qualities we all respect, such as taking responsibility for our work and caring about our patients. Many nurses think of a professional as someone who finds work rewarding and is honest and hard-working. All of these qualities are obviously important ones.

But in sharing our experiences in hospital nursing, we have found that there are other sides to professionalism. For example, many professionals start to feel that they are the only ones who possess the good qualities mentioned above. We tend to forget that the other people we work with are just as likely to be honest and hard-working or to care about the patients and take responsibility for their work. Professionalism teaches us to see ourselves as unique and better than other health care workers. And the more we talked about profession-

---

*The second and concluding part of this article will appear in the July-August issue of Science for the People.*

alism, the more we saw that it was used by administrators to make us work in certain ways which are not beneficial to us or to our patients. In other words, professionalism can be used to exploit nurses.

We have come to the conclusion that professionalism in nursing is being used as both a carrot and a stick. As we try to become more "professional" our eyes are glued on the "carrot" of increased respect, rewards, and supposed improvement — and we do not see that behind our backs, professionalism is providing a "stick" that is used to control and manipulate us. We would like to talk about what's going on in nursing and health care these days, because we believe that professionalism not only does not serve our interests and those of our patients, but more often leaves us feeling unsatisfied, powerless, and isolated from other health care workers.

### PROFESSIONALISM: WHAT WE ARE TAUGHT

Our nursing textbooks talked about what professionalism was in very vague terms, removed from the real work-life of the nurse on the floor. We learned that a professional is someone who has had specialized training which includes a code of ethics, through which members learn standards of behavior to which they are expected to conform. One thing that gives a professional group power is the fact that it is a legally recognized entity: a profession is self-defined, self-regulated. We are told that RNs control their work and set limits on who can perform any given task. (For example, nursing prac-

# Nursing

tice is supposedly governed by the Board of Nursing in any given state.) Finally, while being a professional demands a set standard of performance, the profession is supposed to protect its members and their interests.

Nursing is supposed to be a unique profession in that it's a balance between physical work and using our heads. While giving a bedbath we're doing more than just washing. We can evaluate range of motion and we might notice a rash or the beginning of a bedsore. Frequently we're in the position of making judgments about patients' meds—like holding someone's Valium because they're too drowsy, or their Dig\*, for a slow pulse. Much of the day-to-day information about the patient is channeled through the nurse, who makes decisions about calling the doctor.

The idea that we are more than manual laborers is stressed from an early point in our education. Although we do physical work like other hospital workers, we are taught that we are more like doctors. We have specialized education, we write in patient charts, which are part of a legal record, and we make decisions that directly affect patient care. Doctors will seek us out to ask how their patient is doing. In Social Service rounds we can talk about financial worries or home problems that no one else has picked up.

\*Digoxin, a widely used cardiac medication.

*by the Boston Nurses Group*



Bill Plympton/Health-PAC

Nurses are taught to identify the patient's psychological as well as physical needs — such as helping a patient cope with an ileostomy\* or some other radical body change. We are told that these are skills that other people don't have or are unable to develop without going to nursing school. Another big part of RN training is skill in "leadership" and management of other nursing personnel — taking charge, organizing a team assignment, checking up on other people's work. As professionals, we are told that we are the best qualified to decide how work is done on our unit.

We are promised many rewards for being professionals — good salaries and fringe benefits, job mobility and job security. With a BS or MS we are practically guaranteed the chance to move up the ladder — become a head nurse, supervisor, clinical leader or nurse practitioner. Even if we don't go on to school, workshops and conferences keep us increasing our knowledge. We are supposed to have some independence regarding the pace of work and the priorities we choose to set.

A lot of us went into nursing for another, different reason, that has to do with helping people. A big role we play is that of guardian of the patients' dignity and overall well-being. We want to give them the best possible care and protect them from disappointments. Our needs to feel useful are supposed to be satisfied by the unique and special nurse-patient relationship.

All of these are rewards that we expect from being a nurse. What is the actual situation?

### PROFESSIONALISM: ON THE JOB

We do receive some concrete benefits for being seen as professionals. RNs get paid relatively well — almost twice as much as nurses' aides. We have more job mobility than most workers. We can change jobs, have a family, move away, or quit to go travelling, and still be pretty sure of finding work. There is also mobility within an institution — you can transfer to a less tiring or more challenging unit, although sometimes the promise of a transfer is used to hold you on an unpleasant floor for months.

\*radical bowel surgery.



However, job mobility within nursing is decreasing. With cutbacks in the economy, nurses who leave their jobs often are not replaced. It is harder for new grads to find jobs, and layoffs, especially in public hospitals, are becoming more common. Another factor is that within the past few years there has been a flood of people into nursing. So the old myth that "you can always get a job if you're a nurse" is becoming less true as more people are competing for the jobs.

There is also upward mobility within nursing: head nurse, supervisor, and the new position of clinical specialist. Yet in most hospitals these positions are only open to nurses with BS and Master's degrees. Many hospital-based programs are being phased out and a BS degree is becoming more and more the only acceptable nursing credential. So the drive to "upgrade" nursing serves in the end to make the jobs of nurses without BS degrees less secure. LPNs and diploma grads are being phased out at hospitals where they have worked for many years, and are being replaced by baccalaureate RNs who have little or no clinical experience. At the Cambridge Hospital, for example, the number of LPNs has been reduced from 40 to under 10 in the past few years, and RNs without bachelor's degrees are rarely hired.

But what about the more intangible aspects of being a "professional nurse", for example the nurse-patient relationship. We were taught that we would be the guardian of the patient, enjoying a relationship that no one else who worked in the hospital would have. We would determine the patient's real needs, protect him/her from the errors of doctors and hospital bureaucracy, help her/him figure out and solve all problems. In nursing school we were able to focus our energy on one or two patients at a time, read their charts before or after clinical practice, spend hours at home doing lengthy care plans. We often *were* able to develop relationships that were significant to the patients and fulfilling to ourselves.

But even caring for only one or two patients we "guardians" run into problems sooner or later. One nurse in our group took care of a 55-year-old man who had had a stroke. "The guy was totally freaked out. His whole life was abruptly changed. I called a psych consult because he needed to be able to talk to someone about what was happening to him. The shrink came and only prescribed mood elevators. We wanted to send him home with a homemaker and physical therapy, but he had no medical insurance. We couldn't get state money for home care, so even though a nursing home was more expensive, that's where he ended up, and there was nothing I could do about it." This story is just one example of the many barriers to decent patient care. Even with all the time in the world, we as individual nurses are unable to overcome the obstacles presented by the way health care in the United States is organized.

And once we get out of school most of us don't have all the time in the world. A day on the floor is like a beat-the-clock contest: 7:30 vital signs, 8:00 meds, 8:30 feeding patients, 9:00 baths, 10:00 meds, 11:00 pre-meals,\* 11:30 vital signs, 12:00 feeds, 1:00 putting patients to bed, 2:00 meds, 2:30 charting, 3:00 report. We're as confined to the clock as if we worked on an assembly line instead of in a hospital. There are differences: factory work is more boring, more alienating, often more tiring. The boss is there to tell you that you can't leave the line to go to the bathroom. We have no foreman controlling our every move. But through nursing school and the professional ideals taught there, the boss has moved inside us. We *still* don't get to the bathroom until lunch (if we get lunch).

If we are lucky we are done at 3:30 but probably not, so many nurses will still be running around until 4:30 or so, usually without overtime pay. We don't ask for overtime because we know we won't get it unless the floor is in an unusual crisis. So why do we stay? We are made to feel guilty. We feel that it's our own fault if we don't get our work done even though we know that the real problem is understaffing. A little voice inside may be saying, "Well, if only you were more organized". Or maybe we feel that it's expected, that we can't leave if everyone else stays, and that we don't want to leave all that work for the next shift.

Why do nurses put up with these lousy working conditions and believe the myth that we have control over our work? Because we have an image of ourselves as professionals, we blame ourselves if we don't finish our work, don't develop significant relationships with patients, and don't feel that we have control over our work day. The ideology that surrounds the nursing profession forces us to blame ourselves for situations over which we really have no control, and reinforces our passivity. This ideology keeps us from identifying the real sources of our problems. When we are fed up because of poor staffing, broken equipment, and lousy staff relations, professionalism keeps us from getting together to change our working conditions. Instead, it turns us back on ourselves to examine our own faults.

One of the hardest things about being a new graduate is getting used to the fact that working as a nurse is very different from the "profession" we learned in school. Even if we have time to try to be the patient's guardian we run up against doctors, bureaucracy and the inadequacy of health care in this country. As professionals we are supposed to have control over our working conditions. But we have very little control over some very important aspects of our work — such as staffing (who and how many), hours, quality of care, discharge planning, treatment of patients, who becomes a patient, nursing policies — the list is endless.

\*Testing a diabetic patient's urine for sugar before a meal.



cps

Many of us start work with high expectations of our "expanded" role. Traditional nursing education taught us to be the handmaiden of the physician. But the women's movement has left its impact on nursing. We have a greater sense of our own worth, as women and as men in a "woman's" job, and have started to demand respect from others on the job. Many baccalaureate RNs are taught to see themselves as the physician's colleague. We all expect to make decisions about patient care. But our attempts to exercise our judgment are often frustrated, and we become outraged when we see patients suffer because of it. We take out our hard feelings on other nurses, aides, housekeepers, even the patients. It doesn't help, but what can we do?

The women and men in our group got together because we wanted to do something more constructive with the anger we bring home from work. Many of us had been in consciousness-raising groups, in which we had discovered that our "personal" problems were shared by others. We had learned to look beyond our individual lives for the causes of these problems, and decided to use this skill to explore our "personal" problems as nurses. We started to ask ourselves why there was such a difference between the nursing we were taught in school and nursing on the job. Why did we feel so bad at the end of a workday? Why was it so difficult to give good patient care?

As nurses, we have the goals of better patient care and better working conditions. We decided to look beyond nursing, at the rest of the hospital. Who else shared our problems, and our goals? And why are these goals so difficult to achieve?

## HOSPITALS: IS HEALTH CARE THEIR GOAL?

We asked ourselves if good health care is really the goal of the hospital industry. Most of us who work in hospitals can think of many examples which tell us that other motives come first: unnecessary procedures and operations to provide learning experiences; little or no preventive health care; understaffing or poor equipment when money is being spent for some specialized medical machine already available at another hospital. We frequently find that hospitals are more concerned with profits, teaching and research than with health care. Banking, drugs, supplies, construction, real estate speculation — all are so closely tied into the health care industry that some have called it the “medical-industrial complex”.(1)

Most private hospitals are officially “non-profit” institutions. Usually people think this means that the hospital only takes in enough money to pay for the expenses of patient care and staff wages. In reality, “non-profit” means only that the hospital’s excess income is not distributed to shareholders. But the profits are there — they are used to finance expansion, new equipment, fancy offices and high salaries for administrators. Two advantages of “non-profit” status are Federal assistance for expansion and exemption from taxes.(2)

Recipients of hospitals’ “non-profits” include drug and hospital supply firms. In the 1960s, the drug industry was consistently one of the three most profitable industries in the United States.(3) Hospital supply companies have an almost unlimited future in disposable goods, as hospitals resterilize only the most expensive equipment. Aside from traditional hospital firms, drug companies (like Smith, Kline & French), paper corporations (Kimberly-Clarke) and conglomerates like 3M (makers of Scotch tape) are diversifying into hospital equipment.(4)

Hospital expansion is so profitable for construction companies, lawyers, architects and banks that many areas of the country have too many hospital beds: San

Francisco has 1130 extra beds; Honolulu 1000; Oklahoma City, 1946 extra beds — with more expansion planned.(5) Not only are expansion plans made with little regard to actual need, but the impact on the surrounding community is often ignored. In Boston, residents of the Mission Hill neighborhood have been fighting expansion of Harvard Medical School’s teaching hospitals for 15 years. Harvard is the major landlord in the area, and has been trying to tear down the housing it owns to build the Affiliated Hospital Complex (including Peter Bent Brigham Hospital, Robert Breck Brigham Hospital and Boston Hospital for Women). Rather than providing health services for the community, the original plans would have destroyed one of the few remaining inner-city neighborhoods in Boston. Only constant organized resistance by the Mission Hill residents delays the takeover of their homes by Harvard Medical School.

We hear all the time that there’s not enough money for wages, staffing, or supplies. So it may be a surprise to learn that all this profiteering and expansion is going on. Why is the decision made to spend money building unnecessary hospital beds instead of hiring more nursing staff or buying more wheelchairs? Who decides where the money goes?

## HOSPITAL ADMINISTRATORS: DO THEY SHARE OUR GOALS?

Most private hospitals are run by Boards of Trustees or Directors, who have the final say in policy decisions. Trustees do long-term planning and choose which banks, construction companies, etc. the hospital will use. Actual day-to-day control of the hospital’s policy is more likely to be in the hands of the hospital Director.

The people who sit on hospital Boards of Trustees are frequently the same people who sit on the Boards of companies in hospital-related industries. At Mt. Auburn Hospital in Cambridge, Trustee Ernest F. Stockwell is also president of the Harvard Trust Company, which profited from holding the mortgage on the new Mt.



### Sound Familiar?

In 1974 this man was the highest paid executive in America. He is Michael C. Bergerac, President of Revlon Inc. (whose drug and clinical lab sales comprised 1/3 of their profits). According to *Business Week* magazine his annual salary was \$1,595,000 — more than double what most working-class Americans will make in a lifetime. Just remember, you’re keeping his family from starving each time you give a patient Hygroton.

The Chairman of American Home Products, another drug firm, was the fourth highest paid executive, making a mere \$600,000.

## TRUSTEES: A SPECIAL PEEK

Steve Krasner

Auburn building. Mr. Stockwell is also a trustee of University Hospital, and is a director of a gas company and an engineering corporation. In fact, of the 24 trustees listed for Mt. Auburn in 1972, no less than 14 were directors or Board members of banks or banking-related organizations; three were connected with the realty business; three with power-producing firms; and three were trustees in other hospitals besides Mt. Auburn.(6)

Across the river in Boston, the hospital-corporate connections are similar. Mitchell Rabkin, General Director of Beth Israel Hospital, is a member of the Board of Trustees of MASCO (Medical Area Service Corporation). MASCO proposes to provide hospitals in the Longwood area, such as Beth Israel, with everything from linen to electricity.(7).

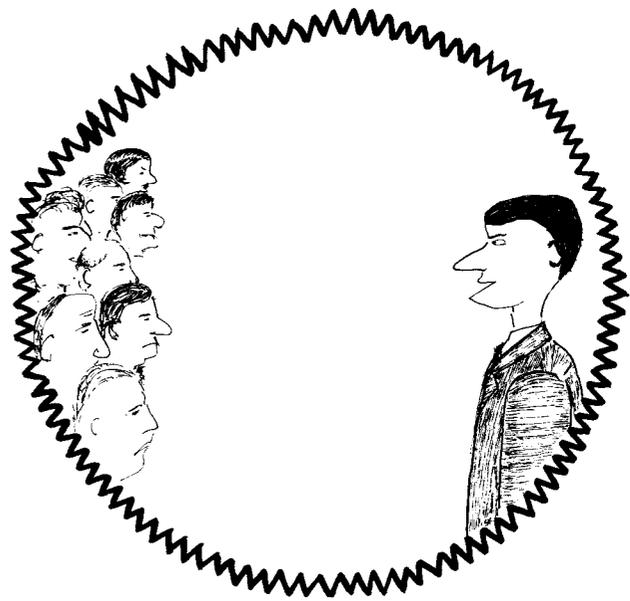
With such close connections, it's not surprising that hospital Boards make decisions that reflect their own profitmaking interests more than the interests of the patients or hospital employees. But what about the hospital Director? Could he/she share our goals?

The Director is usually a person with special training in hospital administration, whose job is to run the business efficiently and save money. It is important to control the workforce, which includes making sure that employees don't step out of line and make costly demands on the administration. At a larger or more prestigious institution, like Beth Israel, the Director may have the same business connections as the Trustees. At all hospitals the Director is the public voice of the Board of Trustees and shares their interests, not ours.

What about doctors? Don't they make a lot of decisions? Can they be our allies in seeking better health care? There are some individual doctors who are genuinely concerned about health care. But as a group, doctors are more concerned with their incomes or with research, or both. Their interests in hospitals are primarily as free office or laboratory space. Interns and residents are in a slightly different position — they are overworked and are more directly affected by understaffing than the private doctors, because it means even more work for them. House officers' associations have occasionally made demands about hiring more lab and nursing workers. But their situation is only temporary — they are on their way up and out, so we cannot depend on them for long-term support in our efforts to gain better working conditions.

### **NURSING ADMINISTRATORS HAVE DIFFERENT PRIORITIES FROM THE STAFF NURSE**

As staff nurses, we are not constantly aware of the top administrators and trustees. We never see them, though they make decisions that affect our life at work every day. Nursing administrators are a little different.



"FIRST WE'LL HAVE THE MEDICAL CENTER BOARD MEETING.  
THEN WE'LL DIVIDE UP FOR THE SEPARATE BANK AND  
CONSTRUCTION COMPANY BOARD MEETINGS."

Though we may seldom see the Director of Nursing, supervisors are usually around, at least for scheduling or to announce new policies. If we have a grievance, we go through "proper channels" — that is, the supervisor's office. It seems as if they should be sympathetic to our problems. After all, they've been trained as nurses — they know the demands of our work. Since they visit the floors, they should have some idea of how many patients we have and what care they need. So it is doubly frustrating when we get no response from a nursing supervisor — or worse, get treated like a nuisance for mentioning problems in the first place. Why don't they know what the floors are like? Why can't they imagine what it's like to have too much work and not enough help — and do something about it?

The point is that even if a nursing administrator has given direct patient care at some time in her career, the majority of them never touch a patient. Their priorities are completely different from those of a floor nurse. The nursing director is supposed to provide nurses for staff duty, but she can hire no more than the budget allows. Staying within the budget is one of the main concerns. She is also expected to manage her personnel by means of the supervisors. This is how hospital policies are put into effect, and how discipline is maintained, whether the issue be wearing caps or signing into work. The director is also expected to keep her department up to par for JCAH (Joint Commission on Accreditation of Hospitals) and public health inspections, stressing

“... we are human as other girls and the law seems to protect girls in other vocations from working more than eight hours.” — a nurse in 1928.

“The graduate nurse of good family, and good education can practically make her own choice as to whether she will accept a position in one of the better institutions, or go into public health or into private duty, but the young graduate of today who lacks breeding and background ... has no such choice.”

From: Burgess, M.A., *Nurses, Patients and Pocketbooks, A Report of a Study of the Economics of Nursing*, New York: Commission on the Grading of Nursing Schools, 1928, pp. 356 and 442 respectively.

things like nursing audits, progress notes and care plans, even if there aren't enough people to do the job properly.

Some supervisors try to listen, and argue for funds to hire more nurses or get more supplies. They may urge staff nurses to document poor patient care due to inadequate staffing. This kind of supervisor usually doesn't last too long since administrators may feel she “can't handle” her job, which is to maintain the status quo. Some supervisors don't care at all about the realities of staff nurses' problems or make even more demands. When the floor is the busiest we are asked why a bed isn't made or why our shoes aren't polished.

### Professional Associations

Nurses who try to take their grievances through proper channels — that is, nursing supervisors or directors, are frustrated and realize they will get nowhere this way. Some RNs consider the alternative of going to their professional organization (usually a state branch of the American Nurses' Association [ANA], like the Massachusetts Nurses' Association [MNA]), either for individual advice or group representation. Nurses are told these groups will give the best help because “nurses need other nurses to understand their problems”. But as we can see from looking at nursing supervisors and directors, the fact that someone is a nurse doesn't necessarily mean they care or can do anything about the problems facing a staff nurse.

Another drawback is that the ANA has a relatively large number of administrative nurses in its top positions. The disadvantage of this can be seen in the example of an operating room (OR) nurse who was worried about understaffing in her area, and asked her state association for help. Unfortunately, one of the association's officials knew the OR nurse's supervisor — and told her friend to “watch out for that trouble-

maker” on her staff. So, having managerial level RNs represent staff nurses does not guarantee impartial help or advice.

In spite of this potential conflict of interest, the ANA considers itself the voice of nursing. It has publicized the ideas of the nursing leadership since it was founded in the 1890's, and takes credit for the improved status of nursing since that time. How did the organization become so prominent, and how much has it worked for the rank and file nurse?

### The ANA and the Staff Nurse

Until the 1920's the average nurse did private duty work, often in the patient's home.(8) Since nurses worked in this way, isolated from one another, it was difficult for them to band together to work on common problems — such as irregular work, long hours without relief, or difficulty getting paid for their work.(9) Thus the ANA, run by financially secure, upper class nurses, was virtually unchallenged in its role as the major nursing organization.

The main goal of the organization has been to make nursing more respectable and prestigious, not always to the benefit of the average nurse. The ANA's work on the issues of licensure in the 1910s and of control of nursing education in the 1920's had some good effects. Licensure standardized qualifications somewhat and made some nurses' jobs more secure by limiting competition. However, it also disqualified some very competent nurses who had been trained outside the hospital school system.(10) The reform of nursing education begun in the '20s eliminated some of the schools that used students' unpaid labor without providing sufficient instruction.(11)

But graduate nurses continued to face difficult working situations and economic insecurity. The Report of the Grading Committee on Nursing Education (1928) mentioned their problems over and over again, but its main accomplishment was to recommend closing some nursing schools and to join the trend begun by the Goldmark Report in 1922 for more education for nurses.(12) The effect was to reduce the numbers of new graduates competing in the job market and also to exclude many women who could have been skillful nurses but who did not have something the Committee called “good breeding”. The feeling seemed to be that if more women from the upper class became nurses, a lot of the on-the-job problems would disappear.(13)

Unemployment among nurses increased with the Depression and it became evident very few people could still employ private nurses. More people entered hospitals for medical care, and the hospitals finally decided (with some misgivings) to staff their floors with graduate nurses in place of unpaid students, as the nursing

schools were getting too expensive to run.(14) Many nurses were reluctant to do hospital staff work, realizing they would lose the chance to give the one-to-one care possible in private duty. Though they gained a regular paycheck, they now had more work than they could do; faced by a wardful of patients, they were forced to lower the quality of their care.(15) They still worked long hours, but had lost their freelance independence — falling under hospital discipline for style of hair and uniform, relationships with doctors, use of supplies. The hospitals compensated by giving RN's a position of minor influence in the hierarchy. Eventually RNs identified with the hospital administration. They "gained" petty control over other workers, but lost control over patient care.(16)

Over the next 20 years, the ANA continued to emphasize collegiate training for RNs. Once again, many people have been excluded from opportunities in nursing, since this type of education requires a lot of money and time. A prime example is that of LPNs, whose education and experience is deemed worthless in most states (by Boards of Nursing overwhelmingly controlled by RNs and MDs). It would be possible to structure LPN education so it would count towards future RN training, but RN leadership has blocked this possibility.(17) RNs with diplomas are hurt by the current trend, too. One diploma RN was enraged by her interview for a BS program: "They treated me as if I'd barely graduated from high school."

While it has been mandating more education for RNs, the ANA has mostly ignored the actual working conditions of the majority of nurses. The organization puts a lot of time and money into legal support of nurse practitioners, but its collective bargaining function is a low priority even though it involves relatively greater numbers of staff nurses. The MNA, for example, is known as a weak bargaining agent, delegating a small proportion of its resources to negotiations and grievance procedures.(18) The mistaken concept of the 1920's seems to persist — if only nurses were "better people" (from wealthier families? with only BS and MSN degrees? working as practitioners? more like MDs?), then these problems of understaffing, lack of supplies, unpaid overtime, etc. wouldn't exist.

There is also the question of staff nurses having any power in an organization dominated by top-level supervisors and educators. From time to time, staff nurses at Boston City have documented instances of unsafe patient care (mostly due to understaffing) for their MNA unit to present as a grievance. Much of the nursing shortage was due to cuts implemented by Ann Hargreaves, Nursing Director of the Department of Health and Hospitals. At the same time, Ms. Hargreaves was

state treasurer of the MNA, signing the paycheck of the staff nurses' bargaining agent, who was in charge of pursuing the grievance. With such conflicts, can staff nurses rely on professional organizations as their advocates on the job?

## WHO DOES SHARE OUR GOALS?

### *Patients*

It seems clear that, lacking the same goals, nurses should expect little support from administrators and professional organizations. But nurses are not alone in their desire for better care and better working conditions. It may surprise us, but patients are strong potential allies. We both share one basic goal — good patient care. We lose sight of this important fact as the pressures we work under alienate us from the people we care for.

Our working conditions force us to neglect all but the most pressing medical needs of our patients. They soon learn that we give more attention to the sickest patients and to the ones who complain the most. Patients end up thinking they have to fight for the care they need and deserve. As a result, they sometimes treat us as if we were enemies, as the immediate representatives of a system that isn't responsive to them.

When patients challenge us, it reminds us that the whole system of health care is not really set up to help people, and that they're suffering from it along with us. We know only too well, for example, that patients are experimented on in blatant and subtle ways, and that we are expected to cover up the resulting mistakes and inconveniences. We sympathize with them. Yet when we are overworked, we see their demands as just one more obstacle to overcome before we go home.



"I'd like to introduce my colleagues. . . ."

This antagonism is neither our fault nor the patients' — it's built into the hospital structure. Earlier in this paper we talked about the ways nurses were incorporated into hospitals in the 1930s: hospital administrators deliberately broke up the one-to-one nurse-patient relationship because it was too expensive. Today, adequate staffing is still too "expensive." Our instincts and training lead us to expect good patient care conditions, but we usually run into trouble on the job if we insist on these conditions.

We think that the solution is not to go back to the days of private duty nursing, but to find ways to get together with our patients to demand better conditions for them and ourselves. Together we could face the real obstacle, the hospital administration.

### **Other Hospital Workers**

The work of the hospital is to provide health care. This work involves a lot of tasks besides giving bedbaths and medicines, changing dressings, and doing patient teaching. Sick people need to be in a clean, safe environment — which means constant cleaning and constant maintenance of equipment. They need to eat special foods, and the food has to be delivered to their bedside. Patients need laboratory tests, X-rays, and respiratory treatments. Drugs and supplies used in their care have to be ordered, stored and delivered to each floor. Records of patient care have to be made, updated and filed. Most of this work is unglamorous and doesn't pay well. But all of this work is absolutely essential. Our work as nurses would be impossible to perform without dietary, maintenance, housekeeping, clerical and technical workers.

The reason we discuss other hospital jobs in such detail is that we have sometimes found in ourselves and other nurses a lack of respect for other hospital workers. One reason for this is that our society values mental labor more than manual labor — so that doctors are more respected than nurses, who are more respected than aides or housekeepers.

We have also been encouraged to think that *we* are the only ones who care about the patients. In nursing school we are taught about meeting all the needs of the patient and forming "therapeutic relationships." But this schooling can make us forget that caring doesn't come from ideas in a book, that you don't have to be "qualified" to care about patients. Caring comes from the person, not from nursing school or professionalism. Many nurses are dedicated, compassionate individuals, and some aren't. It works the same way for other people who are involved in hospital work. If nurses care about patients it's not because of professionalism or training. (Look at doctors with all that training. Do they necessarily care about the patients more than we do?)

Why all this talk about respect? We think that nurses' ignorance about other hospital workers blinds us to the fact that they are the people in health care who have the most in common with us. There are obvious differences in training and pay, but the differences are small when our salaries are compared to those of doctors and administrators. And we face the same problems on the job. Whether one is a housekeeper or a nurse, we have little or no input into hospital policy, wages, employee benefits, staffing, the way health care is delivered, etc. In other words, none of us has much control over our job. If we continue to blame our problems on our fellow workers and refuse to see them as allies, we are only hurting ourselves in the end.

### **HOW DO WE ACHIEVE OUR GOALS?**

To many of us it seems unusual or inappropriate to think of getting together with housekeepers or maintenance workers or of taking joint action with our patients. This is partly because we've always been told that we achieve change by going through proper channels — which means working it out with your supervisor, or trusting some administration committee to work on the problems. The effect is to make us feel that we aren't smart enough or don't know enough about the situation to come up with any good solutions with our coworkers. And of course, administration would like us to think that employees below us are even less capable of solving problems.

We've already stated why we think the proper channels won't get us very far. But what else can we do?

We'd like to give a few examples of situations in which patients and hospital workers joined forces to fight for a health care issue. We'd also like to talk about organizations that other hospital workers have used to defend themselves at work.

### **Worker-Patient-Community Efforts**

In 1975, Massachusetts tried to close the Shattuck Hospital, a large rehab and chronic care facility in Jamaica Plain. The state claimed the hospital was too expensive to run and that it was only half full. Workers employed at the Shattuck felt insecure about their futures. They fought to keep the hospital open and gained a lot of strength from the efforts of former patients and families of patients. The group pressured state legislators, started a sticker campaign and pushed the issue into the media, with successful results: the hospital stayed open.

In the same year, Boston State Hospital was operating with at least 90 staff positions unfilled, and with supplies such as toilet paper and soap unavailable. There was no clothing for patients, and they had to share dinners, as the kitchen could not send enough

food to each floor. Nurses at the hospital organized a demonstration at the State House to demand more funds. This demonstration was attended by 150 staff members and patients. The next day, staff was informed that each patient would receive a new outfit of clothing. But when it was clear that basic conditions were still not improving, RNs and LPNs staged a one-day sickout. That day they were notified that the 90 critically needed positions would be filled.

### Unions

We have two examples of successful coalitions involving hospital workers and patients or community members. These coalitions were formed around a single issue and stayed together for a short period of time, so were limited in what they could do. We need to organize ourselves so that we can work on more long-range goals and deal with many issues. As a first step we need to defend our rights on the job, so that we will be protected in

Steve Krasner



“The Director, please . . . Mr. Tightwad? . . . the care here is outrageous. You need twice as many workers to give good care! You’ll hear from my Neighborhood Council!”

working for the changes we need to make. A good place to start is with unionization, specifically, unionization which includes all workers in a hospital in the same union. The more our group talked about the need for change, the more we realized that hospital unions are an important first step in achieving better conditions.

But nurses often have a lot of fears concerning what unions may do to health care. Some feel that a union is an outside organization, that will tell workers what they have to do. Others feel that unions are "unprofessional," harmful to patients because they promote strikes, and that they will encourage laziness. There are many people who think unions are always corrupt, and that in any event they tend to take in more in dues than they deliver in the contract.(19)

Not all of the fears listed above come out of thin air. But many of them are misconceptions. When workers suffer from low pay, bad working conditions (such as long hours, dangerous conditions, etc.), lack of recognition for their work, or poor benefits, they need to improve their position by joining together so that their employer has to listen to what they have to say. Workers organizing unions realize that when they act only as individuals they can't change the quality of their jobs.

#### *What is a union?*

Collective bargaining is the process of negotiation between workers and management to produce a contract that both sides will agree to. A union is an organization of employees which carries out collective bargaining with the employer in order to improve the jobs of its members.

#### *Patient Care*

Some nurses who are reluctant to unionize feel that improving their own conditions can only take place at the expense of the patients. But just the opposite is true. When people don't like their jobs, they don't do good work. In hospitals, it is important that people have good working conditions since their jobs affect not only them but also the patients, in a very direct way. Nurses, just like all other hospital workers, have the right to demand improvements for themselves. And patients will benefit from good working conditions for *all* hospital workers.

#### *Hospital Unionization*

Unions have a long history in the United States, going back into the last century. It was during the 1930s, however, that large numbers of workers started joining unions. This was the beginning of the unionization of the major American industries. We take this for granted today, but at that time there were many bitter struggles by American workers to establish their unions.

In Boston and in many other cities, most hospital workers are still not unionized. Why has the health care industry lagged so far behind other industries in this regard? For one thing, workers in voluntary\* hospitals were not protected by federal labor laws until 1974.(20) (In some states, local laws were passed before 1974 which gave unions some protection from unfair practices by employers in that state.) Also, in earlier years, hospitals were still viewed as charitable institutions. Nowadays people are more likely to understand that hospitals (especially voluntary and proprietary\* hospitals) are powerful institutions that control large amounts of money. So hospital unionization has only really gotten underway in the last 10 to 15 years.

In New York City, where hospitals are heavily unionized, the minimum wage is now \$181 for 40 hours.(21) But in 1959, before organizing efforts began, the minimum wage in private hospitals was \$30 per week for a 48-hour week.(22) Many hospital workers who worked full-time — or more — were forced to apply for welfare to support a family.

#### *"Unprofessionalism"*

During the 1960s, when hospital organizing and occasional strikes were taking place in some cities, many professionals and professional associations objected to these tactics. Nurses denounced the strikes and broke picket lines. The failure to respect a strike is not surprising in view of the fact that the ANA promoted a "no-strike" policy from 1950 until as late as 1966, when it was rescinded.(23)

\*voluntary=private nonprofit; proprietary=private, profit-making.



The professional associations that once said unions were "unprofessional" have now begun to recognize that they must use the same methods if they want to make progress. What these groups haven't wanted to recognize is that their members' wages have been pushed up largely by the organizing efforts of workers "below" them. As union contracts have improved the wages and working conditions of service, maintenance, and technical workers, administrators have raised salaries of "professional" employees to keep pace.

Inflation, the flooding of the job market and the deteriorating conditions in hospitals have affected us all. Many of us have faced understaffing, floating, inadequate supplies, and cutbacks in benefits. These are the conditions which made nurses in San Francisco, Baltimore, Seattle, Honolulu and Chicago go on strike. These nurses saw that the old appeal to professional sacrifice for the patients' sake is baloney. Nurses have now begun to organize.

If being "unprofessional" means uniting with the majority of health care workers to bring about improvements, instead of trying to make it on our own by becoming a more elite group, then we could use a lot more "unprofessionalism"!

#### *Union Democracy*

Some people fear that a union is an outside organization that will tell them what they have to do. But the activities of a union depend on the activities of its members. When unions are young and struggling, their members are actively involved. As they get bigger

---

#### BREAD AND BUTTER ISSUES — UNIONS DO MAKE A DIFFERENCE

	<i>Boston (largely non-union)</i>	<i>San Francisco (largely union)</i>
<i>Non-government hospitals:</i>		
General duty nurse	\$184/wk	\$211/wk
LPN	148	165
Aide (female)	108.50	145
<i>Non-federal government hospitals:</i>		
General duty nurse	\$188	\$218
LPN	153	164
Aide (female)	123.50	150

Source: Cannings and Lazonick, "The Development of the Nursing Labor Force in the United States: A Basic Analysis", *International Journal of Health Services*, vol. 5, no. 2, 1975, p. 190 (table 3).

---

and stronger, their leaders tend to lose touch with their membership. There are many stories in the press about corrupt union leaders and the lack of democracy in unions. In addition, union leaders are reluctant to challenge the status quo, and often end up justifying management's positions to their membership. These are the possible results of a situation where the union leadership no longer identifies with the workers but spends most of its time talking with managers. (In a professional association such as the MNA, the leaders actually *are* the managers, which is far worse!)

Union members are often encouraged to be passive, and to trust in the leadership to "get things" for them. But unions are only democratic when their membership stays actively involved, and insists that the leaders serve their needs.

#### *Protection on the Job*

Hospital administrators tell us "a union will take all control away from you." But any hospital worker who thinks she already has control over her job is not looking at reality. Even RNs, as we talked about earlier, are not really given any control — just the right to tell other workers what to do. While hospital unions are not going to give us complete control over our work, they are crucial in gaining basic improvements. For example, unionized workers have more protection from unfair practices by supervisors. They have a grievance procedure, which can provide a more equitable way of dealing with problems. Because they have some protection against arbitrary firing, they are less afraid to speak up, to suggest changes, and to get in touch with each other about various issues.

Of course, there are also more concrete benefits to be gained from a union, such as improved health insurance coverage, pension and compensation plans. And most workers feel that the wage increases and other improvements make it very worthwhile to pay dues, which usually run about 1-2% of wages. Dues paid to a union go to help pay salaries for negotiators, organizers, and lawyers, and to pay for the costs of everything from leaflets to contracts.

#### *Hospital Costs*

Another argument commonly used against unions is that they are supposedly responsible for driving up hospital costs. There's more here than meets the eye, however. For example, although total salary expenses for some unionized hospitals have more than doubled, part of this is due to the fact that hospitals are hiring more workers per patient than previously. Secondly, it is necessary to look at which employees' raises take up the greatest part of the increased costs. For instance, in a four-year period in New York City, "while orderlies' wages went from sixty or seventy dollars a week to \$100

**A UNION CONTRACT VERSUS A PROFESSIONAL ASSOCIATION CONTRACT**

The chart below contrasts the benefits of two 1975 contracts for nurses at Babcock Artificial Kidney Hospital in Brookline, Mass. One contract was negotiated for LPNs by the National Union of Hospital and Health Care Employees, District 1199 Mass., and the other, for RNs by the Mass. Nurses' Association. They were negotiated at the same time. Both types of nurses pay dues to their organizations.

	<i>Union benefits for LPNs</i>	<i>Mass. Nurses Assoc. benefits for RNs</i>
<i>Pay raises</i>	30% incremental raises from March 1975 through Jan. 1976; \$47 increase	9% incremental raise for same period; \$20 increase
<i>Medical benefits</i>	100% of all medical and hospital costs for all LPNs and families	80% family medical costs and all hospitalization; for <i>full-time</i> RNs only
<i>Dental benefits</i>	85% of family costs	None
<i>Prescription drug benefits</i>	All family prescriptions paid	None
<i>Maternity leave</i>	13 weeks leave at 2/3 pay (untaxed)	Unpaid leave
<i>Staffing</i>	Formal bimonthly meetings with management to deal with staffing	RNs have no say
<i>Management rights</i>	Management may not do anything arbitrary, capricious, or in bad faith	No controls on management authority

Other benefits such as holidays, vacations, liability insurance are identical for RNs and LPNs. Finally, whereas members of the union have the legal right to strike (if they so choose) for a new contract, the MNA has agreed in writing never to strike under any condition (even if their members choose to do so).

a week [ = \$5200/yr.] in New York . . . the average net income of full-time hospital radiologists were jumping from \$26,000 to \$34,000.”(24) Probably most important

is the fact that nonlabor costs have risen as rapidly as labor costs. Because Blue Cross and Medicaid accept the hospitals' estimates on the cost of care, hospitals have been able to buy large amounts of complex equipment and expand their research according to their own priorities. They then include all this in their calculation of costs, so that the cost-per-day of treatment has risen dramatically. Through their insurance premiums, the consumers, instead of the hospitals, actually end up paying for both necessary and unnecessary “improvements.”(25) Thus there are many reasons for increased hospital costs, and better wages are only a part. It is time that hospital workers stopped subsidizing hospital costs by sacrificing their living standards through poor wages.

**FROM THE HORSE'S MOUTH**

*Notice how we always hear that higher hospital costs are due to wage increases? But, according to the Council on Wage and Price Stability, half the increase in health care costs comes from the increase in new services and purchases. The other half is taken up by increases in both wages and materials. This means that considerably less than 50% of the rise in hospital bills can actually be attributed to wage increases.*

(Staff Report, Council on Wage and Price Stability, *Problems of Rising Health Care Costs*, Executive Office of the President, April 1976, p. 12, table 6.)

**Laziness**

Do unions encourage workers to be lazy? There is no guarantee that anyone will work more or less hard in a unionized hospital. But it *is* possible to see where lazy-

ness comes from. When people don't see their jobs as leading anywhere, when they have supervisors over them who don't work or who are disrespectful, when they get low pay for long hours: this produces the feelings of "alienation" that make us feel like "it's not worth it" to try hard to do a good job. Hopefully, by increasing the benefits available from a job, and the amount of input a worker can contribute to the workplace, we will all feel more positive about the quality of our jobs.

### Strikes

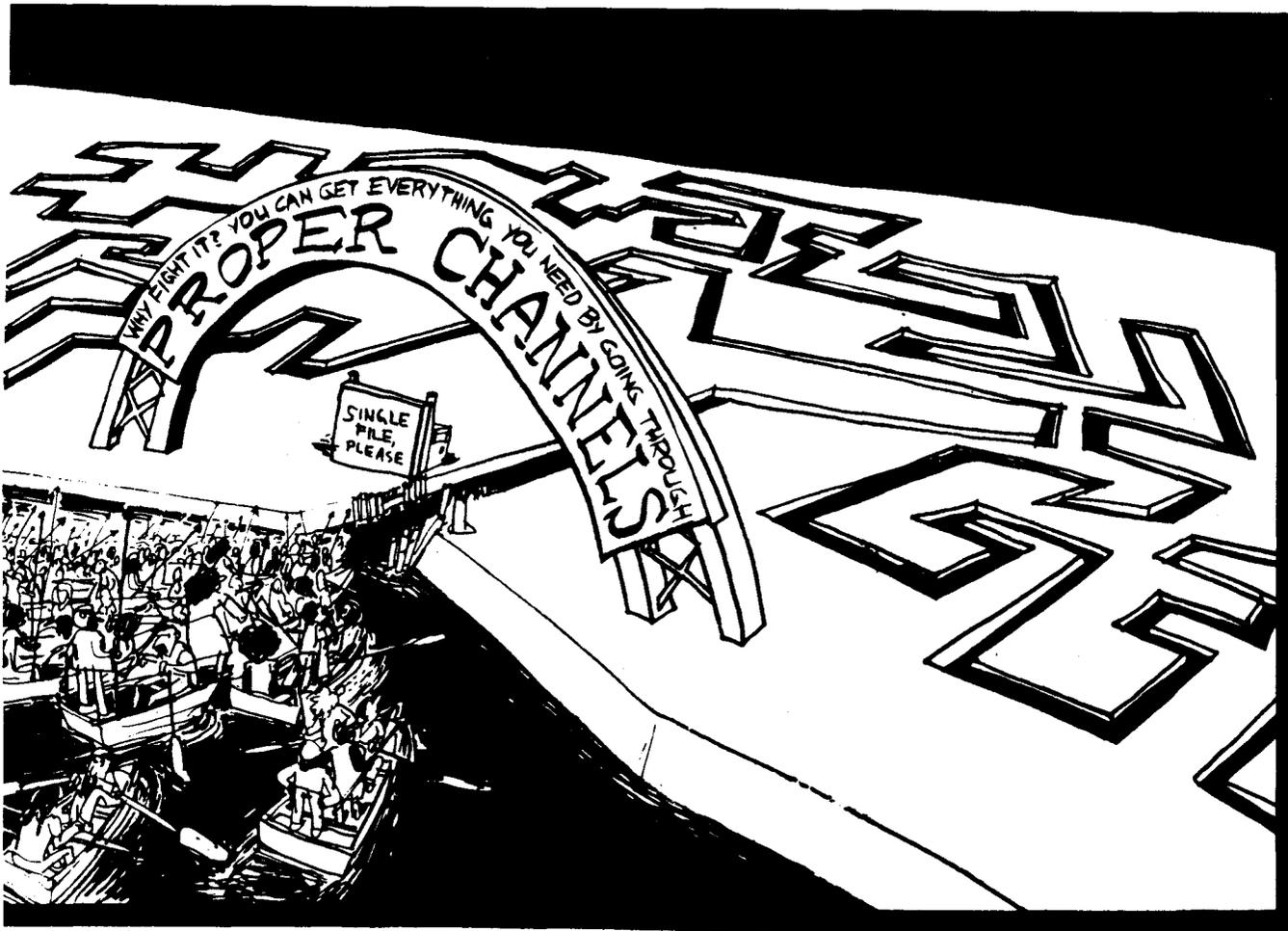
But what about strikes? If nurses join unions, won't we be forced into strikes, and isn't that bad for patient care? These are important questions to answer, because this is the tactic that nurses object to most frequently. Strikes are given a lot of attention in the press, and administrators always try to use them to scare workers away from unions.

For one thing, unions do not automatically lead to strikes. Once in a union, workers have more ways available to solve conflicts than they had previously.

Workers cannot be forced to strike by their union. A strike takes place only when the workers in the hospital vote for it.

People do not enjoy going on strike. When issues are being negotiated, a strike is usually the last resort, after all other methods have failed. Management does not give in to our demands because they want to. They give in because they are forced to. They control the conditions of our work; the only control we have is whether or not we work. A strike is a statement by workers that unless management recognizes their right to what they're asking for, they will refuse to work. Nurses make this statement all the time, whenever we quit to look for a "better job." But acting as individuals, we have no power.

It is certainly true that strikes cause hardships for patients. What can be done about this? There is a federal requirement that the union must warn the hospital in advance that it is planning to strike, so plans are made by the hospital before the strike to provide for essential patient care. (This law was made primarily to benefit the hospital's economic interests, not to help the patients.) However, strikers have often taken the responsibility to



Nick Thorkelson/cpf

ensure patient safety during the dispute. In Connecticut, for example, striking nurses sent a team into the hospital each morning to check on critical patients and to see if any extra measures needed to be taken.

Hospitals are often willing to run their floors with poor staffing, creating conditions every day which are dangerous for patients. Yet when we refuse to work under these conditions, we are the ones who are accused of endangering patients. A strike is a short-term hardship, but it is one which management forces into being, one which becomes necessary in order to make long-term improvements. When workers improve their job conditions they are creating a better hospital for themselves and for their patients. The same thing happens on an individual basis when a nurse refuses to take an assignment she feels she is not trained for, or refuses to put up with conditions that are unfair. In the short run, it might or might not have been better for the patient had the nurse done what she was told. But in the long run, conditions would definitely deteriorate if no action were taken.

Lastly, administrators say that strikes show that unions have destructive effects on patient care. But we've seen that it is administrators' lack of concern for patient care, and their business priorities, that usually make for poor conditions. How can unions be responsible for deteriorating patient care when it is the hospital that has had control over such issues as staffing, bed space and supplies? It is in the unions' interest, as well as in the interest of their members as health-care consumers, to improve patient care as much as possible. □

#### REFERENCES

1. Ehrenreich, Barbara and John, *The American Health Empire: Power, Profits, and Politics*. New York: Random House, 1970, p. 29.
2. Feshbach, Dan, "The Dynamics of Hospital Expansion," *Health-PAC Bulletin*, No. 64 (May-June 1975), p. 17.
3. Ehrenreich, *op. cit.*, p. 99.
4. *Ibid.*, p. 102.
5. Nichols, Bob, "Oklahoma Crude", *Health-PAC Bulletin*, No. 57, (March-April 1974), pp.1-2.
6. Research by the Mount Auburn Workers' Committee.
7. *Articles of Organization for the Medical Area Service Corporation*, Chapter 180, May, 1972.
8. Burgess, M.A., *Nurses, Patients and Pocketbooks, A Report of a Study of the Economics of Nursing*, New York: Commission on the Grading of Nursing Schools, 1928, p. 249. Cannings, Kathleen and William Lazonick, "The Development of the Nursing Labor Force in the United States: A Basic Analysis", *International Journal of Health Services*, Vol. 5, No. 2, 1975, pp. 192-201. Reverby, Susan, "The Emergence of Hospital Nursing", *Health-PAC Bulletin*, No. 66 (Sept.-Oct. 1975), p. 10.
9. Burgess, *op. cit.*, p. 332. Reverby, *op. cit.*, p. 10.
10. Cannings and Lazonick, *op. cit.*, pp. 192-201. Reverby, *op. cit.*, pp. 9, 14.
11. Cannings and Lazonick, *op. cit.*, pp. 192-201. Reverby, *op. cit.*, pp. 9, 14.
12. *Ibid.*, p. 14.
13. Burgess, *op. cit.*, p. 442.
14. Cannings and Lazonick, *op. cit.*, pp. 192-201. Reverby, *op. cit.*, p. 14.

15. Burgess, *op. cit.*, p. 353. From 1928: "Floor duty in hospitals is too hard and often with not enough help, and one has no time to do the little things for patients that often mean much to add to their comfort and health."

16. Reverby, *op. cit.*, p. 15.

17. Cannings and Lazonick, *op. cit.* Reverby, Susan, "Health: Women's Work", *Health-PAC Bulletin*, No. 40 (April 1972), p. 17. Ehrenreich, Barbara and John, "Hospital Workers: A Case Study in the New Working Class", *Monthly Review*, Jan. 1973, p. 18.

18. According to the February 1977 *Massachusetts Nurse*, pp. 3 and 6, the 1977 MNA budget allocated less than 1/3 of its non-salary expenses to the Department of Economic and General Welfare. There is no strike fund.

19. Godfrey, Marjorie, "Someone Should Represent Nurses", *Nursing 76*, June 1976, pp. 73ff.

20. "Health Workers Unionize", *Dollars and Sense*, No. 15, March 1976, p. 13.

21. Information from 1199 office, New York hospital workers, etc.

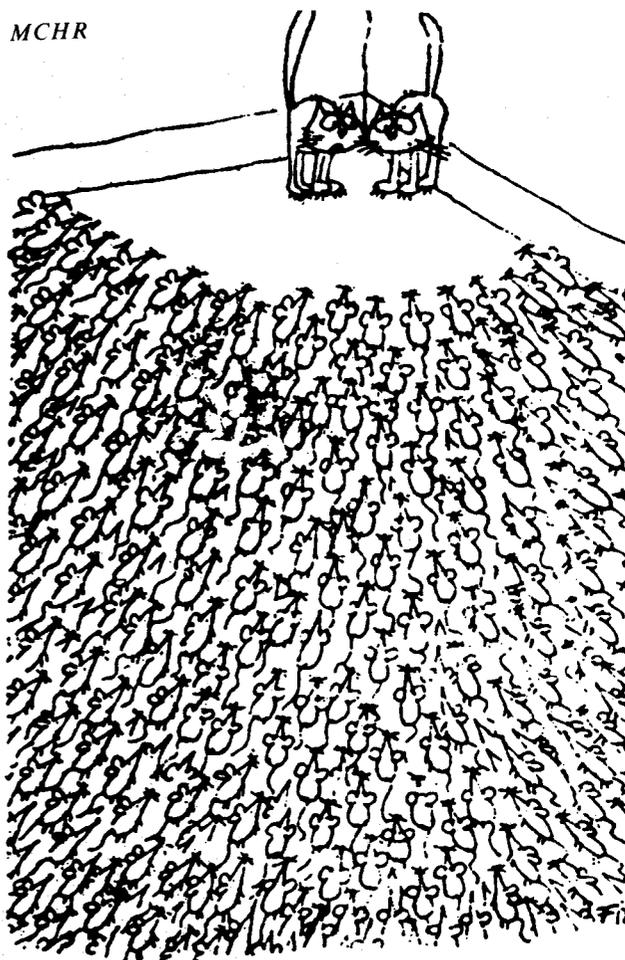
22. Ehrenreich, *American Health Empire*, p. 138. "Health Workers Unionize", *op. cit.*, p. 13.

23. Epstein, Richard and K. Bruce Stickler, "The Nurse as Professional and as a Unionist", *Hospitals*, Vol. 50, January 1976, p. 48 (footnote #10).

24. Ehrenreich, *American Health Empire*, p. 139.

25. *Ibid.*, pp. 140-144.

MCHR



**"Well, don't just stand there—negotiate!"**

# S.T.G. GOES to SCHOOL

by the Ann Arbor SftP Science Teaching Group

For years the Ann Arbor Science for the People Science Teaching Group primarily held intellectual discussions of how science teaching has perpetuated the elitist and oppressive role of science. Science teaching, we felt, has been instrumental in reinforcing the popular notion that science is politically neutral and value-free. Lost in the intellectual abyss, we neglected to find out what is actually going on in the classroom. Mostly, we were afraid of finding out either that our concerns were unfounded or that our idealism was nothing more than just that. Knowing we could no longer remain blissfully ignorant of the real classroom situation we valiantly decided to organize a workshop to meet science teachers and discuss our concerns with them.

In November 1977, we contacted the science coordinator for the Ann Arbor public schools and distributed invitations to all Ann Arbor area science teachers. The workshop, on Dec. 3 was titled, "Science: Its Social Consequences." We wanted to 1) discuss the resources we had available to teachers, 2) find out from them what was going on, and 3) find out how social issues could be interjected into their classes. To our great surprise, and despite several positive responses, only two participants attended. Fortunately for us they were the science and social-sciences coordinators for the Ann Arbor public schools. In the ensuing discussion, we expressed several of our concerns, which were well received. The result was that they became our conduits to transmit information to the science-teaching community. Our mistakes, though, were obvious:

scheduling the workshop for a Saturday, and not giving them more information about ourselves.

We regrouped, and not despairing, we vowed to make contact once again; we planned another workshop. This time we prepared a letter of introduction, a list of our available literature and, in conjunction with other SftP subgroups, several lesson plans on sociobiology, food additives, alternative technology and nuclear power. The science coordinator helped us schedule the next workshop for March 3, the Ann Arbor public schools in-service day. Due to our initial contacts, a second flyer-invitation and our presence at the Michigan Science Teachers Association meeting in February, we expected a much better turnout. And we got it.

Sixteen science teachers came to our second workshop. After a brief introduction, there was a rousing discussion on science and social issues: the ideology of Pure Science, public input into science, the global nature of science problems and how science arises out of a social context, e.g., military and industrial research. Generally, the teachers' reaction was favorable but not overly enthusiastic. A couple of people were hostile, while several were genuinely interested, and the rest remained an enigma. The interactions after the meeting were helpful in suggesting future directions for our group.

It was clear the SftP subgroups could be a valuable resource in providing speakers for high school classrooms. In fact, we arranged for our Energy group and a local Nestle boycott group (INFACT) to speak at the alternative public high

school in Ann Arbor. The students expressed great interest and as a result other subgroups will appear there soon. We are currently developing a speakers list to distribute to the other teachers. Other suggestions from the teachers were: writing a lesson plan on the misuse of statistics, reviewing current textbooks for political content or lack thereof, and continuing our discussions and contacts in future workshops.

In retrospect, the workshop could have been more effective if we had been better prepared with a more refined and practiced presentation. In addition, breaking into smaller discussion groups would have been more conducive to the teachers' expressing their feelings and experiences on science teaching. Lack of clarity about our goals created unnecessary difficulties. We have to better assess our purposes in establishing these contacts before we plan our future activities. Despite these misgivings, we discovered the teachers shared many of our concerns and at least some of our idealism. □

---

## SOCIAL ISSUES IN BIOLOGY

A 12-month, student-initiated study leading to a Master of Arts Degree. Potential projects include the political economy, ideology and biology of social behavior, agriculture, health, population and environment.

For further information, call or write: Mark Wilson, Goddard/Cambridge Graduate Program, 186 Hampshire St., Cambridge, MA 02139. Tel. (617) 926-5436.

---

# SUMMER AT SEABROOK

Cynthia Benjamins



## Clamshell Will Return in Force

by Frank Bove

Seabrook, NH will again be the stage for massive nonviolent civil disobedience to protest nuclear power. The Clamshell Alliance, a New England-based organization of 53 local groups, is planning an "occupation/restoration" of the nuclear plant construction site on *June 24*. The call has gone out nationally and internationally for support. Anti-nuclear activists have been encouraged to organize actions

*Frank Bove is a staff person in the Cambridge office of Clamshell Alliance.*

at nuclear plants in their locales. The Crabshell Alliance in Seattle is also organizing a site restoration and demonstration for June 24.

### Nonviolence Preparation

For Clamshell, this will be its fourth occupation of the Seabrook construction site. Like the three previous actions, all participants will receive nonviolence training before they occupy. Occupiers will form into affinity groups of 15-20 people. Each affinity group will provide

food and other forms of physical and emotional support for its members. Unlike the three previous actions however, Clam is planning to "restore" the site by setting up projects demonstrating the potential of alternative, renewable energy sources (e.g., solar and wind energy) in agriculture, aquaculture, and silvaculture (tree products).

There is a strong possibility that a huge police and national guard force, under the command of New Hampshire's ultra-rightist Governor Meldrim Thomson, will be amassed

at Seabrook to confront the occupiers. In preparation for this likely event, Clamshell has drawn up guidelines for an orderly, peaceful action. These include:

- 1) All occupiers must have preparation in nonviolent action before taking part in the June 24 occupation.
- 2) No weapons of any kind.
- 3) No damage or destruction of Public Service Company of New Hampshire (PSC) or Seabrook property.
- 4) No running at any time.
- 5) No strategic or tactical movement after dark.
- 6) No breaking through police lines.
- 7) No dogs.
- 8) No drugs or alcohol.
- 9) In case of any confrontation, we will sit down.

Falls have refused to sell Public Service Co. the water essential for construction. PSC faces increased statewide opposition to its 17%, \$27 million rate-hike request. PSC has already raised the rates 17% in anticipation of a favorable ruling by the NH Public Utilities Commission. Seabrook has joined seven other New Hampshire communities which have registered their opposition to the rate hike for "construction work in progress" (CWIP). Finally, PSC still lacks federal EPA approval of the plant's controversial cooling tunnels.

Encouraged by the successful Seabrook occupation last spring, anti-nuclear groups have sprung up nationwide. The nuclear industry is attempting to stem the tide of nuclear opposition by launching a well-financed campaign, with the help of Clamshell's position that nuclear

power is uneconomical and dangerous. A RAND study claims that construction costs of nuclear power plants will double in real, uninflated dollars, every six years or less because of recurrent design failures. The Seabrook plant began as a \$970 million project, but now the estimate is \$2.5 billion and could top \$3 billion. PSC has claimed that it will need rate hikes every year until 1984 in order to construct the Seabrook plant. Recent studies on the effects of low-level radiation upon workers have shown that radiation levels previously presumed safe are now proving to cause cancer and leukemia. At the Portsmouth Naval Shipyard, maintenance workers repairing nuclear sub reactors have a cancer death rate twice the national average and nearly 80% higher than the rate for other shipyard workers.

As the case against nuclear power becomes stronger, the nuclear in-

---

Although construction continues around the clock, there has been a growing antinuclear sentiment in New Hampshire.

---

dustry will be forced to step up its campaign of retaliation. However, despite "rough rider" Thomson's intentions to thwart the occupiers, the Clamshell action will undoubtedly receive worldwide attention and extensive media coverage, and will once again demonstrate the growing strength of the people's movement to seize control over decisions which affect our lives.□



Cynthia Benjamins



### Growing Public Opposition

Although construction of the \$2.5 billion Seabrook plant continues around the clock, there has been growing antinuclear sentiment in NH. For a decade, seacoast people have fought against the plant in the courts. Two years ago, Seabrook and seven other New Hampshire towns voted against the plant in town meetings. More recently, Seabrook and neighboring Hampton

President Carter's pollster Pat Caddell, to reach out to people they categorize as having "low socio-economic status." Clamshell has also been working hard to reach out to unions and to workers on the site to inform them of the dangers and uneconomics of nuclear power, the hazards of radiation at the workplaces, and the job-producing potential of cost-efficient, safe and renewable energy alternatives.

Recent reports have confirmed

---

# news notes

---

## SPEAKING OF DIESELS

As automakers tool up to produce millions of new diesel-powered cars and light trucks, a growing body of evidence suggests that the widespread use of diesel engines could generate enough carcinogens to seriously threaten public health.

This threat, should it be confirmed, will be most serious in densely populated cities. Diesels emit a complex array of particulates and cancer-causing hydrocarbons. The volume of these emissions, the way they react with other substances already in city air, the amount of time they remain in the air, and their apparent affinity for human lungs could enormously magnify their impact.

While both diesels and catalyst-equipped gasoline engines emit comparable levels of HC, CO, and nitrogen oxides, diesels emit far more nitrogen dioxide, a substance that acts as a poison in human lung cells at levels that already exist in the air over many cities.

Nitrogen dioxide aside, diesels spew forth 50 to 80 times the particulates and especially harmful hydrocarbons that gasoline engines emit. These substances are unregulated, not yet fully catalogued, extremely complex, and extremely numerous. They exist attached to minute particles made up of still smaller particles. When viewed through a scanning electron microscope, the large particles (which are less than 10,000 angstroms across) look uncannily like sticky popcorn balls. The small particles are between 100 and 800 angstroms in diameter. Once these substances leave the tailpipe, they enter the atmosphere, where about 90 percent of the particulate count remains airborne up to 40 days. This is a relatively long time, though polynuclear aromatic hydrocarbon (PAH) compounds retain their original structures for only several days at most. Furthermore, the chemically active air of large cities encourages ongoing, harmful chemical changes. PAH particles, for example, react with

other pollutants and change into new carcinogens, some of which may be more potent than their progenitors,

The urgency is real because, as dieselization nears the economic point of no return for the auto industry, eliminating or regulating the effects of diesels will become progressively more difficult, even if harmful effects are found.

—*New Engineer*, April 1978

## THE NEW "UNTOUCHABLE"

More than 350 company doctors and industrial hygienists recently held a meeting in Denver to discuss the "hypersusceptible worker." The hypersusceptible worker theory is becoming an increasingly popular tool to help industry avoid cleaning up the workplace. The theory is based on the premise that if a worker suffers adverse health effects caused by the working environment, the worker is at fault, not the working environment — the particular worker must have an inherited tendency to develop disease when exposed to certain conditions. There is a growing tendency among company physicians to set up rigorous pre-employment physicals in order to weed out those workers with these inherited tendencies; this will supposedly relieve the company of cleaning up the work environment. A company will screen workers out of a job rather than clean up the work environment.

Dr. Paul Kotin, medical director for the asbestos-producing Johns-Manville Corp., and an enthusiastic proponent of such weeding-out examinations, suggested that the new class of unemployable workers created by this screening be taken care of by the government. Indeed, the new class of "untouchables" created by hypersusceptibility screening would have to become dependent on welfare payments, since employers would be extremely reluctant to hire them.

—"Lifeline", *OCAW Union News*  
Jan. '78

## HARVARD ENERGY PLANT UPDATE

The Harvard-controlled Medical Area Service Corporation (MASCO) has been building an energy plant in the Mission Hill section of Boston, adjacent to the Harvard medical complex (see *SftP* March-April 1977, for a history and discussion of both this project and the strong and sometimes successful community opposition which the project provoked). The plant, known as the Medical Area Total Energy Plant (MATEP) will produce steam, chilled water and electricity for the Harvard medical area complex at a construction cost of \$109 million. In addition, the plant will emit twice as much nitrogen dioxide as the World Health Organization, the American Lung Association of Massachusetts, and other groups consider safe.

On January 31, 1978, those opposed to the plant achieved a significant victory. The Massachusetts Department of Environmental Quality Engineering forbade MASCO to generate electricity with diesel generators because of the high nitrogen dioxide levels which would be produced by these generators. Harvard, however, has continued full-speed in building the MASCO plant. MASCO recently placed an ad in the *Boston Globe* for utility power engineers experienced in diesel generators. An applicant for this position was told by the MASCO Director of Facilities that there was no question that diesel generators would be used in the plant — after all, Harvard has already purchased the six generators and they are now being stored in a Boston warehouse. Harvard quite simply expects to overturn the Department of Environmental Quality Engineering decision on appeal. Those who want to help prevent this should contact the N.O. MATEP Coalition (Neighborhood Organizations against the Medical Area Total Energy Plant), P.O. Box 525, Brookline Village 02147.

—N.O. MATEP Coalition

LETTERS, *continued from p. 5*

Dear SftP,

In apparence, content and style you're the *best* magazine on the left. . .

I agree with Al Weinrub that political content needs careful attention to present a clear and attractive alternative to liberalism. . .

I'd like to see short snappy articles about organizing efforts. Not long pieces explaining the background, etc., but short *quick* outlines of the issue, what the people *did* (tactically and strategically) and how it came out, with a short critical evaluation. Emphasis should be on the *action* not the background.

Would like to see a lot more emphasis on what people *can actually do*. Should people join the Clamshell Alliance? If so, we should say so and encourage people to do so. It is in our interest for as many people as is humanly possible to gain *concrete* political experience.

The move to health and women's issues has given the magazine a shot in the arm. Tie-in to the women's liberation movement is extremely important.

Think Gar Allen is wrong, Ruth Hubbard is right, but issue needs careful attention to avoid polarising into either-or. Consciousness is very low about scientific patriarchy on the Left.

Have always thought that *critical* articles about current research would attract new readers. SftP should have a definite opinion about quarks, for example.

Joe Schwartz  
London, England

Dear SftP,

It's good that the articles are so long — enables the authors to really put forth the complex analysis and strategic considerations necessary to be useful to me in my situation, and to give fair criticisms of a particular program, trend, or whatever.

Excellent when articles about organizing are included. I'm definitely looking for everything I can find about the subject. Also it's very useful to have articles about the social causes and political nature of various scientific

developments, e.g., birth control. I'd be particularly interested in articles of this sort on medical technology — critiquing recent trends and providing a positive model for where medical science could go, even if very vague — and medical research. As well, linking these and other features of health care and the political and economic situation of health care workers and consumers, instead of focusing so much on corporate involvement in setting priorities, would be useful to me in trying to change our (students' and workers') roles in the whole affair.

When I get my R.N., I'll definitely become an SftP member, as then I'll be able to contribute financially to it. I definitely consider it to be a valuable resource. Your openness to discussion and input is very commendable. Though I'm not a member, I've come to feel a sense of responsibility for the magazine because of your openness. This sense definitely makes me read it more frequently and cast an eye towards what can be done for the magazine.

Barbara Simons  
Dayton, OH

---

## EDITORIAL GUIDELINES

The goal of **Science for the People** is to examine the role of science and technology in society, in order to encourage progressive political activity.

Articles in **Science for the People** come out of the experience and interest of its readers. We urge everyone to contribute to the magazine. We welcome articles written collectively. Good articles can evolve from collective and individual political work, from research, or from other activities. Articles can take the form of book reviews, personal accounts, reports of events, analytical essays, etc. Writing done for another purpose can often be adapted for **Science for the People** and is welcome.

Contributions to the magazine should: 1) deal with issues of science and technology from a radical perspective; 2) sharpen political awareness; 3) stimulate political action on issues of science and technology. It is important to use straightforward English and to keep technical terms to a minimum.

**Procedure:** 1. New articles: submit 3 copies (manuscripts are not usually returned, so don't send originals unless

you have kept a copy for yourself). The Editorial Committee works hard in revising articles and discussing them with authors. You may want to send an outline of a proposed article to the Editorial Committee in advance for response to content and emphasis, and suggestions for source materials. Final substantive changes are cleared with authors. In the "About This Issue" column, the Editorial Committee may describe the range of opinions on a particular issue, point out unexplored questions, or draw some additional implications from the articles.

2. Articles written for another purpose: submit 3 copies, along with a letter describing the article's origin, and whether or not it may be adapted.

3. Current Opinion: Submit 3 copies. Contributions should be about 500 words, tightly argued positions on timely subjects, including occasional contributions from the Editorial Committee. The Editorial Committee may discuss with authors changes which clarify debate.

4. Readers are also encouraged to contribute letters, News Notes — news

items on the social and political role of science and technology, and especially reporting people's activities around these issues, Chapter Reports and SftP Activities — brief summaries essentially assured of publication, and graphics — cartoons, designs, photographs, etc., not necessarily original but with credits.

**Science for the People** is a collective effort of the Editorial, Production, and Distribution Committees (volunteer) and the Magazine and Office Coordinators (paid). All committees are accountable to the membership of Science for the People through the annual Eastern Regional Conference. Members of Science for the People outside the Boston area are encouraged to participate (by mail or in person) in the work of the Editorial Committee. People interested in reviewing and editing articles should contact the Magazine Coordinator through the Boston SftP office.

**Circulation:** Currently about 1800 subscribers, with a total distribution of 4000 copies per issue.

**Science for the People**

897 Main Street  
Cambridge,  
Mass.  
02139



Bulk Rate  
U.S. Postage  
**PAID**  
Boston, Mass.  
Permit No. 52696

CHARLES SCHWARTZ 1/79I  
PHYSICS DEPT.  
UNIV. OF CALIF.  
BERKELEY, CALIF. 94720

---

## Subscribe to Science for the People!

---

**Regular Subscription**

I enclose \$6 for a one-year subscription (six issues).

**Gift Subscription**

I enclose \$6 for a gift subscription to be sent to the name and address filled in on the margin or on separate sheet.

**Member Subscription**

I enclose \$15 or whatever I can afford (\$\_\_\_\_\_) for membership in SftP organization. This supports the organization and includes a one-year subscription to the magazine, to the Internal Discussion Bulletin, and to other internal communication that may be put out by the organization or local chapters.

**Institutional Subscription**

Enclosed is \$15 for a one-year institutional or library subscription.

Name \_\_\_\_\_  
(Please print)

Address \_\_\_\_\_

Zip \_\_\_\_\_

You may want to fill out some or all of the following:

Telephone: ( )

Occupation:

Interests:

Local chapter in which I'm active:

- I would like to be contacted by other people who are active or want to be active in SftP
- I'd like to start a chapter or be a contact person for my area
- I'd like to help distribute the magazine
- Names and addresses of friends who might like receiving a sample copy of the magazine (on separate sheet).

Make checks out to Science for the People and send to: 897 Main St., Cambridge, MA 02139.  
Foreign subscriptions are sent by surface mail unless other arrangements have been made.