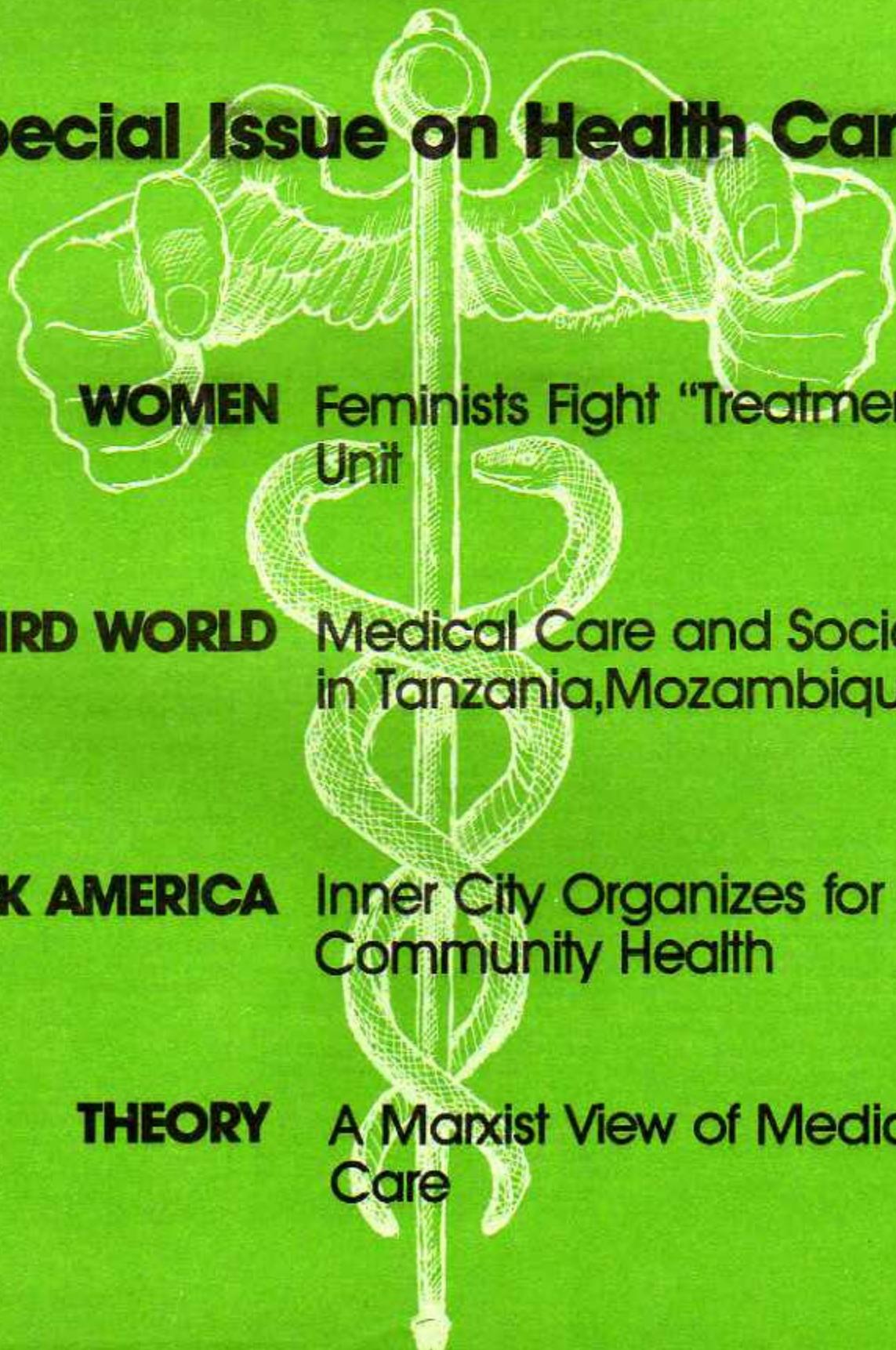# SCIENCE FOR THE PEOPLE

Special Issue on Health Care

WOMEN Feminists Fight "Treatment" Unit

THIRD WORLD Medical Care and Socialism in Tanzania, Mozambique

BLACK AMERICA Inner City Organizes for Community Health

THEORY A Marxist View of Medical Care

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.

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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.

inside

about this issue

Health care is an important problem worldwide. The articles in this issue on health care range from concrete struggles in the U.S. to alternatives in other countries to theoretical analyses of the problem.

The article on institutional oppression of women and the proposed Worcester, Mass., Special Consultation and Treatment Center for Women was written by a collective of women that is directly involved in the struggle against institutional violence and the ideology that legitimizes it. The article shows that the "Worcester Ward" would not be a rehabilitation center as claimed. Instead it would be another of the many women's prisons that are designed as political weapons to suppress the angry reactions of women striking out against a system of male-dominance and oppression. The article exposes the role played by psychiatric-medical ideology in legitimizing a concept of "normality". By defining as "abnormal" behavior that threatens the status quo, this ideology serves the interests of those holding power. The theory and practice of psycho-therapy are, consciously and unconsciously not aimed at enabling people to lead fulfilling lives. Rather, they are aimed at constraining and altering patterns of behavior that do not conform to the societal norms which support a system that ignores the needs of most of the people. The institutional violence committed in prisons like the Worcester Ward — violence including not only physical abuse but confinement and various forms of psychological torture — is justified as therapy necessary to rehabilitate "sick" and "violent-prone" inmates. Groups like the Coalition to Stop Institutional Violence are using every means possible, including legal and legislative, to stop concrete manifestations of institutional violence such as the "Worcester Ward." They demonstrate that such prisons are not "aberrations" but are logical results of the existing social order.

* * *

Howard Waitzkin's article shows how a Marxist analysis of medical care grows out of the study and critique of social relations. Rather than simply reducing ill-health to the malfunction of physiological processes or the invasion of microbes, a Marxist analysis sees these physical events are interacting with social, political, and economic events. Thus, it points to change in social relations as an important way of improving people's health. Although largely theoretical, the review raises questions of practice, particularly the issue of reformist versus revolutionary social change, which are central to the problems facing the Left today.

* * *

John McKnight's article on the struggle of an impoverished Black community in Chicago to improve its health concretely illustrates one way of working for a people's science. The local community organization discovered that the conventional health care facilities were not effectively dealing with the causes of ill-health. They saw the causes as social rather than physiological and began a grassroots effort to enable community residents to improve their own health. The struggle was progressive in that it attempted to educate people about the inherent problems of a professionalized, self-serving medical system and to show them through practice that they were capable of taking control over various factors that affected their lives. Such a process of education and empowerment is a prerequisite to revolutionary change.

Yet, there are dangers connected with the type of reform work described in the article. One danger is that the achievement of some progressive changes will obscure the limited nature of the reforms they achieved and the ways in which the existing political and economic system poses obstacles to further reform without profound and widespread social change.

Another danger is that the "self-help" nature of the reforms may lead to cooptation in the form of victim-blaming; i.e., those in power will claim that the success of the people in improving their own lives shows that they were responsible for their problems in the first place. This type of cooptation can be undercut by educating people about the true roots of their problems and about the limits these place on their ability to improve their own lives within the context of the present system. The contradictions that exist in all types of reform work cannot be denied, and they are difficult to overcome — as the histories of many initially progres-

letters

REACHING TO STRETCH AND EXPAND

Dear SftP:

I'd like to say that I view the magazine as a good vehicle for the membership to expand their viewpoint and develop skills in communicating and defining issues in the broad areas of science and its social and economic matrix. It's more important that these skills be developed and the magazine be part of such a living process than it be of a consistent, high caliber and quality of articles.

The magazine is very uneven but despite all the letters expressing concern about the language, either rhetorical or technical, there is a broad potential audience that has a smattering of different vocabularies from the sciences and readings in political science.

The magazine carries articles that are real reachers. That's when a person or group writes something about what is a true life experience for them. For example, the article by the Boston Nurses Group Part II ("The False Promise: Professionalism in Nursing, PartII", *SftP*, July/August 1978) has been sought out by groups here in the Bay Area and consequently we (the SF chapter of SftP) are now supplying two new stores. Personally I like articles with a good data base and bibliography that can lead me to further resources, even if the analysis is weak in the articles. Best of all is minds reaching to stretch and expand, putting technical information into a broader context.

I really enjoy the feeling of participation and vehicle of discussion the magazine provides, in contrast to a perhaps glossier, more consistent point of view and static type of Scientific American for the "leftish".

Thank you so much for the effort put into the magazine!

Barbara Williamson
San Francisco, CA

ORGANON EXCHANGE

Dear Editor:

We write to protest what we consider to be an unfair attack on an ad we ran over seven years ago. Obviously no one checked Phyllis Lehman's article which ran in *Newsday* for an update on the facts (see *SftP*, Vol. 9, No. 6, Nov-Dec. 1977, "Protecting Women Out of Their Jobs"). We stopped the ad in 1971 because we recognized that it could be interpreted as sexist and contrary to equal rights for female employees. It was never our intention to promote anything but good preventive medical practice for all women of childbearing age.

As the situation stands now, we feel that our Company has been misrepresented to your readers. In order that they not remain misinformed, we request publication of an editorial clarfication, or this letter, in your next issue.

Cordially,
Aldo J. Marchioni
Director of Marketing
Organon Diagnostics
West Orange, NJ

Editorial Committee reply: Organon's ad appears in the Nov. 1977 issue of SftP magazine as an illustration for the article "Protecting Women Out of Their Jobs". Following is an excerpt from the ad: "Before the company hires her . . . you should make sure she's not pregnant." It adds ". . . find the pregnant before your company gets involved in costly training programs as well as health and sick-pay coverage . . . So, save your company's money and save your applicants the eventual emotional stress of a surprise pregnancy . . ." Although the ad is seven years old, we believe it displays sexist attitudes still prevalent among industrial employers today, attitudes which translate into practice which serve the employers' interest at the expense of the workers.

LESBIAN HEALTH

Dear SftP—

I recently discovered *Science for the People* when a rommate brought a copy home. Normally I wouldn't even bother to read a periodical with the word SCIENCE branded on it so boldly. The only reason I did was the article on Lesbian health issues. It was excellent, very comprehensive, and well worth reading. I found myself stopping periodically, amazed that a non-womyn operated journal had published such a straightforward article.

I felt ambivalent about its accessibility to men. Part of me felt violated; another part was glad that men and non-Lesbian wimmin had the opportunity to at last be accurately informed about the pressures we Lesbians deal with daily. I'd like to thank SftP for printing it and Mary O'Donnell for her work.

Looking through the July/August letters, I was disappointed but not surprised to read Jon Campbell's short postscript. I suggest that he take a look at his "good conscience" for it reeks of male sexism. Men often find Lesbianism "both unnecessary and disgusting" particularly when confronted with it in non-word form (in this instance, the comic strip which Roberta Gregory was daring enough to print in non-lesbian context). Personally, I found the comic to be useful in its lightness within the context of a no-nonsense presentation. Comments such as Jon Campbell's remind me that there's still a long, hard struggle ahead before Lesbian art, health issues, lifestyle can be accepted with the validity which is our due.

—Lori Eason
Grand Rapids, MI

OHIO FARMWORKERS STRIKE

On August 24, migrant farmworkers, led by the Farm Labor Organizing Committee (FLOC) struck tomato fields in northwestern Ohio. The number of workers on strike is difficult to gauge, but estimates range from 2000 to 5000, out of a total work force of 8900.

The strikers are demanding a raise from 25 cents to 35 cents per hamper, a guaranteed minimum wage of $3.25 per hour (some growers currently pay up to $2.65 per hour), guarantees of work, health benefits, mileage allowances, and a right to participate in the annual contract negotiations between the growers and the canners as a third party.

The last demand highlights one of the novelties of the strike, that it is directed primarily against the canneries rather than the growers, though inevitably the growers get hurt. FLOC's reasoning is that the growers are not actually independent businessmen, but rather are hired employees of the canneries. The growers contract with the canneries to grow a certain amount of tomatoes. In some cases the cannery even supplies the tomato plants. From what the grower is paid, s/he must then meet all his/her expenses, including labor. Thus FLOC feels it is necessary to participate in these negotiations to win real improvements for farmworkers.

The growers' reaction has been particularly violent. They have attacked strikers with baseball bats, shotguns and pesticides. Part of the grower's fear is that they will be represented in negotiations with the canneries by FLOC. Having lost any real independence, they fear being depressed to the same level as the migrants.

The canneries have also not reacted very favourably. Libby's, whose plant was shut down for 14 hours by pickets before a court injunction and arrests put an end to mass picketing, has filed a $1.25 million damage suit against FLOC for losses due to the strike.

The success of the strike can be gauged from the farmers, who are now paying high school students 40 cents per hamper to pick tomatoes, and from the U.S. Agricultural Dept. Crop Reporting Service, which reported that by Labor Day only 15% of the crop had been picked, while by that time in the season more than 40% of the crop should have been in. Already FLOC is preparing for next year. It is organizing a migrant boycott of the state of Ohio, so that the only migrants to come to Ohio will be strikers.

Obviously this work requires a lot of money, so FLOC needs your help. Donations should be sent to: FLOC, 714½ S. St. Clair, Toledo, Ohio 43609.

—Peter Downs, for
the Ann Arbor SftP
FLOC Support Group

"LOVE" SURGERY

Dr. James Burt, a gynecologist in Dayton, Ohio, claims he has found a way to improve upon the female anatomy. For years, he surgically tightened the vaginal opening of women patients (without their knowledge) in order to bring the vagina and clitoris closer together. He now has developed a $1,500 "reconstruction" of women which changes the angle of vaginal access so that during intercourse the penis stimulates the clitoris. Burt's "reconstruction" consists of mutilating the major muscle between the vaginal and rectal walls (the pubococcygeus muscle), cutting back the clitoral hood, and tightening the vaginal opening.

Critics of the surgery note several serious side effects for women: the severing of the pubococcygeus muscle significantly increases the risk of the uterus and the rectum collapsing; infection and urinating difficulty are highly likely due to the urethra being pulled into the vagina; natural childbirth is made virtually impossible because the natural route of the head of the baby is changed; the reconstruction also requires that the woman be under the man during intercourse.

All of these changes happen to a woman's body under the guise of bringing about sexual "pleasure" for her — but a surgery that brings with it such potential pain, not to mention an entirely alien set of genitalia for a woman, clearly has men's interests at heart, and men's alone. The operation provides a way for men to avoid putting any effort into women's sexual pleasure, and comes at a point in time when it has only been recently acknowledged that women should have orgasms as well as men.

Rather than exploring a heterosexuality where women's sexual needs are as valued as men's, the most efficacious answer has become the remaking of women's anatomy for the sole purpose of synchronizing with the male way of acheiving orgasm. The operation relegates women's sexual needs to a secondary status and represents a clear example of remaking women to fit men's image of what they should be. The "selling" of the surgery also plays on women whose self-images have already been beaten down. In reality, the operation follows the medical tradition of violence against women, such as clitorectomies (female castration), infibulations (sewing the vaginal opening tight so as to insure virginity), and forced hysterectomies, etc., which can only exist in societies where women are considered less than human.

As for James Burt, who profits from his lucrative business of mutilating women, we have a "reconstruction" suggestion for *him*: penile retroversion and insertion.

—Boston feminists
working against
violence against women

UPDATE ON ENSENADA

Since the 11th of September the students of the Unidad de Ciencias Marinas in Ensenada, Baja California, Mexico, have organized a stoppage of all classes, research, and other academic work in protest of the lack of basic funds to function normally. (See *SftP*, Jan./Feb. 1978 issue for background to this struggle.) This *paro* (strike) has the support of most of the faculty, staff and service workers of the school, and considerable effort has been spent in explaining the strike to the surrounding community in an attempt to educate and build up support. These efforts have been rather successful considering that the port city of Ensenada, sixty miles south of the U.S.-Mexico border, is not a lively center of political activity in Mexico.

The students have also occupied certain lands surrounding the school that the state government promised to buy for expansion four years ago. Students are camped out on the land despite a plethora of scorpions and black widow spiders, and some are engaged in a symbolic attempt to build a library building and an auditorium (these too were promised by the governor of the state a year ago).

Other demands include:

1) a minimum budget for teaching, research, laboratory materials and extension of community services.

2) adequate salaries to attract and keep qualified fulltime faculty.

3) various democratic reforms, including local control over part of the budget and the democratic election of the Rector of the statewide university system.

This *paro* takes place in the background of a threatened strike by the service workers, a chronic shortage of money, and a two year struggle for democratic methods of work and administration waged by all sectors of the statewide system (Universidad Autonoma de Baja California).

The Unidad de Ciencias Marinas is one of Mexico's major schools of marine science and its only school of oceanography on the *licenciatura* level (equivalent of the BS level in the USA). Its focus is on the further development of

the sea as a food resource, and the viewpoint of the school is distinctive in that it does not approach the problem as an isolated scientific question but also treats the social, political, and economic aspects of the problem.

Predictably the local press has blamed "outside agitators" for the unrest at the school; specifically Chilean professors have been named as the villians.

WORKERS FIGHT COMPUTERIZED SPEED-UP

The several month-old strike by Teamster warehouse workers in Richmond, Calif., against Safeway and three other grocery store chains has been spreading.

The strike was started by Teamster Local 315 at the huge Safeway distribution center in Richmond in response to the installation of a computerized system called Methods Time Measurement (MTM). Safeway installed the system this year in order to increase worker productivity. The system was devised by the supermarket chain's industrial engineers, who spent one year observing the activities of warehouse workers and figured out a plan to get more work out of employees.

The system works like this: every morning each worker is handed a computer-print-out sheet which specifies the number and type of crates he must load onto his pallet truck within a 60-minute period. If the worker falls behind the pace set by the computer more than once, he will be suspended. If he lags behind three times, he will be fired.

"Safeway officials assured us that (the computer system) would be flexible," said one warehouse employee, "that it would take into account the various ages and physical abilities of the workers. That was a lie. This system is inhuman." A co-worker called it "automation of human beings." The 1,100 warehouse workers have been out on the picket line since July 18 in protest of this speed-up, which has increased each person's workload by "at least 50 percent", according to a Local 315 staff member. More than 80 workers have suffered disabling injuries, primarily back and shoulder strains, while 50 others have been fired or suspended for failing to meet the higher production standards.

The strikers have been picketing Safeway stores and those of three other grocery chains in this area. They have received some support from members of the retail clerks local. The strikers' strategy, however, is to cut off supplies to the retail stores by asking workers at other Safeway distribution centers on the West Coast to go out in support of their strike. The MTM production system has been or will be installed in other Safeway distribution centers. As a result of strikers' efforts, Safeway warehouses in Los Angeles, Denver, San Diego and Salt Lake City were closed due to walkouts there.

Negotitations have been sporadically underway, with a deadlock over Safeway's insistence on writing the MTM system into the new contract. Workers say they will never go back to an MTM shop. Safeway has labeled the strike a "wildcat" and its officials are meeting with representatives from the International to work out a settlement. The International has not sanctioned the strike and has urged Local 315 members to return to work. This appears doubtful, however, until both Safeway officials and International union represetnatives recognize and agree to the Local's demand about the automated speed-up.

—info from *Guardian, In These Times*

THE WORCESTER
VIOLENCE AGAINST

I originally entered a mental institution voluntarily, believing I could get help there. At that time I was very unhappy; clinically it's called depressed. In retrospect I would prefer to call it a terrible unhappiness with the state of my life. I was so unhappy that I was unable to get out bed for days and weeks at a time. Within a few months of institutionalization I had been transformed from a woman who could not get out of bed to a woman who was screaming, kicking, trying to break down doors and break windows.

In the institution I found out that I was systematically lied to about myself and about the program. When I objected, I was ignored.

The last straw came over a seemingly trivial incident. I was told that I would not be allowed to go on a picnic that our group had been eagerly planning and discussing. I had not been told up to this point that I was not going to be allowed to go, even though I had been taking part in all these discussions. It was not the simple incident of not being allowed to go on the picnic, but the cumulative result of all these lies and deprivations. I started to shout at the staff members why I was so angry about being deprived and I was totally ignored. So I went into my room and I picked up a lamp, a little desk lamp, and I broke out the windows in the door to my room ... I had been very angry about those windows when I saw them because they meant that by coming into the institution I had been deprived of even my right

The Coalition to Stop Institutional Violence, a coalition of feminists in the Boston area who have major commitments to the Women's Movement or to the advocacy movements for prisoners and psychiatric inmates, has been successful to date in delaying the construction and opening of a proposed behavior modification unit for women in Worcester, Mass. This unit has been defined as a small maximum security "treatment" facility for so-called "violent" women.

to privacy. So I broke out these windows and I got a very tiny cut on my thumb ... I finally got some attention from the staff ... two staff members came and grabbed me ... they told me that because I had this injury they were going to give me a tetanus shot. They did not explain why this was necessary, they just said "you are going to be given a shot" and that made me more angry and I ended up having a fight with four or five staff members. I never knew that I had that kind of strength. I think it was the anger, the depth of the anger, that created that kind of strength.

What were my violent acts? I was hitting. I was striking out at the people who were keeping me imprisoned, lying to me, and then denying they had lied to me. I was harming the physical building itself ... I broke windows and banged on walls because I saw the building as a prison. I can imagine how such an incident would be written up on my hospital records ... "Patient broke windows ... was subdued by staff ... was given tetanus shot." Nothing about why. Nothing about what led up to it. Nobody looked into the source of my very legitimate anger at being denied human and civil rights like the right to communication and the right to visitation.

There are now two ominous little notations on my hospital records. They say "sui" and "homi" ...suicidal and homicidal. Now, I never actively tried to kill myself although at that time I was so unhappy that I certainly thought of it as a viable alternative. Although I did strike staff members in rage at the mistreatment I was receiving, no one was ever injured. I think that's a long way from homicidal behavior.

What happened to me is not unique. Mental institutions are very efficient at transforming people from merely unhappy people into "dangerous, violent" people ... to use their terminology. Yes, I was trying to defend myself against the people who were keeping me imprisoned; who were torturing me.

WARD:

WOMEN

by the Coalition to Stop Institutional Violence

If this woman were in a Massachusetts psychiatric institution today, it is quite likely that she would be targeted for what is euphemistically called the Special Consultation and Treatment Program for Woman (SCTPW) or the Worcester unit. This proposed unit is a joint venture of the Massachusetts Department of Mental Health (DMH) and Department of Correction (DOC). It is defined as a maximum security "treatment"* unit for women "who have by reason of severe mental illness a recent and repeated history of behaviors harmful to themselves or others and for whom all attempts at treatment in existing facilities have failed."(1)

It should be noted that the Department of Correc-

*Throughout this article, many traditional concepts that the Coalition challenges appear in quotation marks. We hope that the frequency of the quotation marks is not disruptive to the reader. We have left these concepts in question to illustrate the abundance of psychiatric concepts that need to be seriously criticized.

tion is responsible for the blueprints of the unit. The place is clearly a prison. On the fifth floor of an old state institution is a long ward of open dayrooms on one side and individual "adjustment" rooms on the other. The exit is guarded by three metal doors and $50,000 worth of steel security equipment. The isolation cells marked "adjustment" rooms make clear that what is intended is for women to adjust and become the way staff say they should be — adjust to this grossly abnormal institutional setting in order to be called normal and "well".

Five Years of Struggle

The history of this proposed unit goes back beyond 1973. It is easiest to trace, however, by starting with the attempts in 1973 by DOC to commit women to Bridgewater State Hospital. Bridgewater by law is restricted to men. In 1973 DOC illegally shipped a number of women from the state prison for women to Bridgewater. They were returned to the prison through legal action taken against DMH and DOC. Annual attempts to change the laws so that women could be sent to Bridgewater failed as recently as 1977, even though the Worcester unit site was first proposed in late 1976. Since that time, there has been a moratorium on Bridgewater legislation regarding the transfer of women.

The basis for the current plan for a unit for "violent" women was created by DMH and DOC in the fall of 1976. This was done by an internal administrative move, which made it possible to bypass a special legislative study and a public hearing on the nature of the proposal. The chairperson of the Senate Ways and Means Committee, in a special meeting, generously offered start-up money of $150,000. Despite increasing public opposition, subsequent program money was appropriated, requiring legislative approval of only one line item in the massive state budget and avoiding
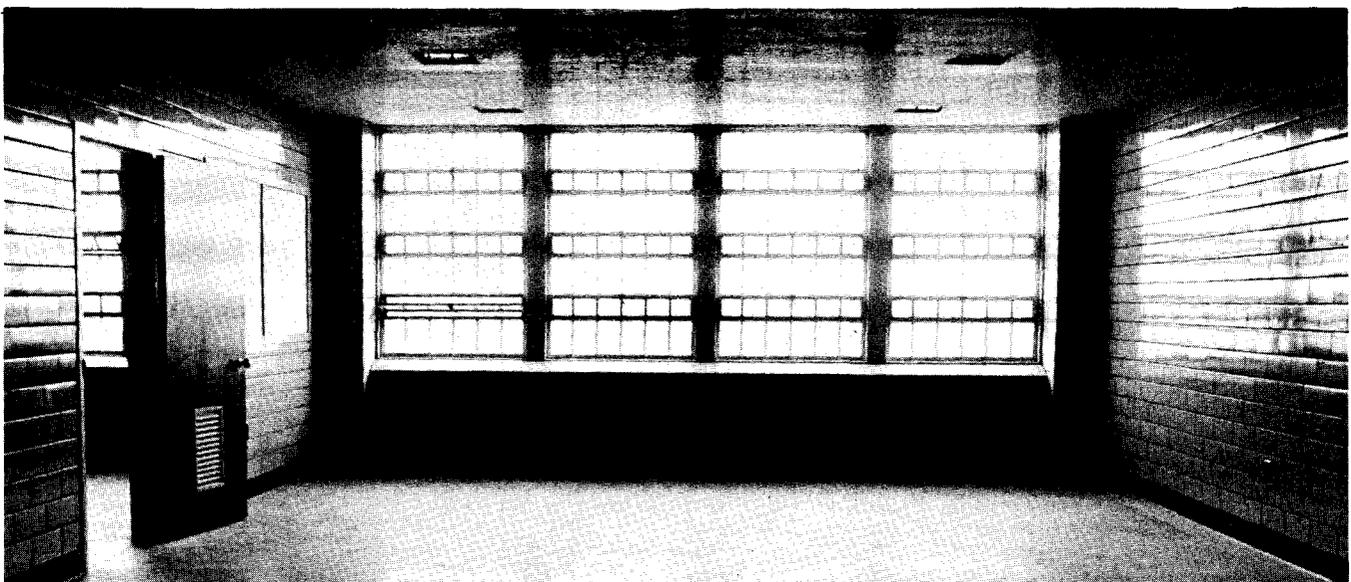
review or statutory approval. In short a "program" that could not make it legitimately through the front door of the legislature was slipped in the back door.

It is clear that DOC and DMH are deadly serious about achieving their unit at all costs.

Throughout 1973-76, the attempts to create a unit for women labelled violent were opposed by an ad hoc coalition of legislators and advocates, representing the prisoners' and psychiatric inmates' rights movement, and the Women's Movement. In 1976 when it was clear the state was increasingly committed to a unit, women from the same three areas of advocacy came together to form an ongoing, formal coalition, the Coalition to Stop Institutional Violence (CSIV). The Coalition's primary goal is to stop the proposed unit through education and public mobilization, petitions and demonstrations, legal and legislative work, and support for alternative shelters and healing places for women. Through the use of all these methods over the last five years, the Coalition and its growing number of supporters have prevented the opening of this proposed unit.

One of the most significant accomplishments of the Coalition has been to force DMH to go through the Department of Public Health's Determination of Need process. This review process is required by law before any new health care facility, representing major capital expenditure or substantial change in service, can be built. DMH was forced to this public review through a taxpayer's law suit filed against them. Determination of Need requires an applicant, in this case DMH, to prove concrete need of the particular facility or service desired and offers opponents, organized into taxpayer groups, the opportunity to contest an applicant's position.

Based on their history, we don't believe the DOC and DMH can truly assist women without radically altering their approach. The proposed Worcester unit does not represent such a change. DMH presents as a rationale for the unit the need to provide "effective clinical treatment to . . . patients whom the system has failed to treat adequately for many years."(2) We can all agree with them that the system fails as well as oppresses women, and children and men as well, and the two departments have contributed to that failure. The return rate to psychiatric institutions and prisons, the number of people who never leave them and the conditions of the lives of those who do. are well-known realities of that oppression.

Psychiatry

The proposed Worcester unit is not an aberration or an abuse of psychiatry, but an example of psychiatric ideology. Psychiatry claims to be apolitical, yet is highly political because it denies the reality of oppression and power relationships or the need for societal change. Psychiatrists are part of a political economy in which we are supposed to give up power to specialists. Psychiatrists are specialists on how we should think. They are in fact mind police, who act to protect the interests of the ruling class.

Much of psychiatry, even in private therapy, is based on the concept of a "sick" person, the patient or client, and the "healthy" professional person. In the community, "sick" people are separated from "well" people so that even those not involved as workers in psychiatry see themselves as different from the "mentally ill". These "mentally ill" are then further labelled "schizophrenic", "psychotic", "obsessive-compulsive", "manic-depressive", "border-line", and on and on. All these terms isolate actions, called symptoms, from a

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Because this article grows out of the struggle to defeat a proposed behavior modification women's unit, we have chosen to talk predominantly of women. We recognize, as part of our work, the oppression of institutionalized men and children, but realize that our choice to focus upon women's lives and issues is not made in a political or social vacuum. As feminists, we know that the rising violence against women in this culture is not unrelated to the strength of the current Women's Movement. Patriarchal attempts to keep women in the role of second class citizens — whether these be manifested by individual men or by society's institutions — will continue to rise as women fight off the sexism which envelops our lives.

We have every reason to believe that as the fight gets harder, the male power holders in society will extend their labelling to include every women who participates in the fight. This has started already. We need only look at the admissions guidelines for the new maximum security unit at Alderson Federal Prison (similar to the proposed Worcester Unit, incidentally) to see that women who participate in "sophisticated political groups" are prime candidates. There are no guarantees that women doing political organizing will not be labelled "violent" and sent to units such as the Alderson unit and the proposed Worcester Unit.

Yet, at the same time that the violence against women is increasing, it is the Women's Movement which has given rise to the types of self-help programs that are truly responding to the needs of women in crisis. By insisting that shelters for battered women, transitional residences for women in emotional crisis, etc., are to be woman-run, woman-controlled, and with a philosophy that strives to empower women rather than strip them of what little power they do have, the Women's Movement has created models for social change which meet women's real needs.

—CSIV

woman's personhood and entire life; isolate her from other people because she is seen as a frightening object that is other than human. All future actions are seen only in relation to these labels, with other possible social causes discounted. These labels separate a woman from social and political issues as well as from her own pain and confusion.

The proposed Worcester unit is based on false and sexist assumptions about "normal" behavior for women. DMH talks instead about "behaviorally dangerous" women, indicating their belief that the cause of violence originates from within individual women. This belief forms the basis of the proposed Worcester unit and its "treatment" facilities.

The power structure of psychiatry becomes clearer when we look at state institutions. Psychiatrists, making the largest salaries, make the decisions; but it is the workers in descending order of status, training, and pay who have increasingly the most, or only, contact with inmates. Workers, often in a ratio of 1:20, are expected to police inmates even if they would prefer to relate to inmates as people they respect and care about. Thus, workers are victims of their hierarchical and alienating work institutions. The presence of a few well intentioned, skilled, and caring staff does not change this basic structure of psychiatry whether it is the proposed Worcester unit or any other facility. This phenomenon is not unlike our larger society where middle management "professionals" maintain control over the working class, the young, poor and Third World people for the ruling class. Inmates of course have the least power over what is done with their lives.

Eighty-five percent of psychiatrists in all psychiatric institutions are men and nearly all are white. Women, Third World people, poor and old people are found in larger proportions in state institutions than in the larger society. For example, non-whites are only 12% of the population of Massachusetts, but comprise 23% of the state mental institution admissions in 1975.(3)

Community "mental health" centers can reach far more people with drugs and therapy than state institutions ever could. The administrators and psychiatrists of these centers, however, are not from the working-class communities in which they often are placed, but are generally from white and privileged communities. The centers once again try to channel individuals into dependence on the "healthy" elite. They discourage awareness that the personal is political and discourage self-help in the true sense of the word. Thus they actually discourage community action on many issues. They focus on individual "sickness" rather than, for example, unemployment and lack of child care.

Just as all women are reacting to the tensions and brutalities of everyday life, many women who have in the past been classified "violent" or "psychotic" were simply relating to the tensions and brutality of the lives they led or to conditions in the institutions in which they were incarcerated. The authoritarian environment of the institutions is only a reflection of the world outside. The power relationships are the same. Women still have little control over their lives or bodies and consequently have little power.

To focus on the actions of a few women labelled violent is to obscure the violence of our society that is capable of driving each of us to assaultive behavior. Who of us has not struck out at self or others in rage or frustration? The Coalition does not deny the occurrence of such behavior. But our response has to be grounded in a societal analysis of the cause of such behavior. Building a facility solely for security and control is the categorical opposite of solving societal problems and supporting women as they resolve their crises.

Psychiatric Prisons

Psychiatric institutions are the most brutal side of psychiatry. The poor are housed in state institutions. The living conditions are intolerable — bad food, over- and under-heating, and generally old buildings in poor condition. Physical, psychic, and sexual abuse are a constant in inmates' lives. There is an unusually high death rate in psychiatric institutions. Although the grounds are sometimes lovely, they are out in the country, hard to reach for friends and relatives without cars. Inmates are only sometimes allowed the "privilege" of being out on the grounds. While there has been a decline in state institutional populations, there are countless people in the United States who have been locked up ten years or longer. People released from the institutions are generally pressured, encouraged, or threatened into the aforementioned "mental health" centers where much of the "treatment" continues.

People are treated by specialists in art therapy, music therapy, dance therapy and talk therapy. This alleviates boredom perhaps, but it often avoids the real reasons why the person was originally seeking help or forced into the institution.

Private institutions are for those with money and good insurance policies. While looking different, nicer and maybe seeming less oppressive, they operate on the same principle and towards the same goals.

Contrary to the stereotype perpetuated by the media, the vast majority of people locked down in mental institutions have not committed or been accused of acts of violence. Rather they have been incarcerated on the judgement of a psychiatrist about possible future behavior, without benefit of a jury of their peers. Or they have turned in desperation to psychiatry in an attempt to resolve their unhappiness.

Institutional psychiatry gains control over people

in several interconnected ways, through the use of brutal and dangerous "treatment" including many forms of involuntary, behavior modifying techniques and through use of the concept called "medical model".

Treatment

The most prevalent form of treatment in institutions is drugging. Ninety-five to 98% of all inmates are drugged, most often with a group of drugs called phenothiazines, (thorazines, etc.). No one claims these drugs cure anything. Their stated purpose is to make people more amenable to "talk therapy". Their effect, though, is to numb, smother and control all thoughts and feelings. Most people are drugged immediately on admission to psychiatric institutions. The real purpose of these drugs is to break down defenses built up in an effort to cope with one's environment. These defenses are defined as "inappropriate" by medical standards.

The side effects of these drugs are their main effects. Nearly everyone given the drugs gets some of these problems: blurred vision, shuffling gait, muscle spasms, tension, need to walk constantly, fatigue, thirst, weight gain, sexual dysfunction and many more including tardive dyskinesia or sudden death. Over one-half get tardive dyskinesia, a kind of brain damage resulting in grotesque symptoms.(4) Victims are unable to control certain movements. They pucker and smack their lips and protrude their tongue. For some their bodies twist, their legs jiggle and shake, and their arms flail. This brain destruction is entirely caused by doctors.

These drugs are used in all closed institutions — reform schools, nursing homes, and prisons. They are also used on "outpatients", in public schools, and community "mental health" centers. "Minor" tranquilizers such as valium and librium are used by millions — mostly women — through private therapy or family doctors. The bulk of the profits of drug companies in the United States are made on psychiatric drugs.(5) These drug pushers have an operating profit margin twice, and in some cases three times, as large as that of some of the other major United States corporations.(6)

Seclusion is often used as "treatment" although in Massachusetts it is restricted by law to emergency situations (as determined by staff). The seclusion room is a cheerless and cold cubicle with a mattress thrown on the floor. When you are put into a seclusion room, you are typically thrown on the floor, stripped and given a shot of a phenothiazine. Then the door is closed and you are left — naked, shivering and helpless. It is a totally humiliating experience. Seclusion is used as punishment for infractions of even the most minor nature. By separating patients and isolating the rebellious, seclusion becomes a direct attack on inmate solidarity.

Other overt, brutal forms of "treatment" and behavior modification are psychosurgery, restraint and

shock (running an electric current through the brain causing a grand mal seizure). Shock causes destruction of brain cells and often permanent memory loss. Psychosurgery is still done — about 500 cases a year in private practice. HEW is considering guidelines which would expand the legal use of psychosurgery to institutionalized people and to children. Despite assurances that psychosurgery will not be used on women at the proposed Worcester unit, it is perfectly legal in Massachusetts and could be done at a facility other than the proposed unit.

One of two kinds of restraint is most often used: the straitjacket, which ties an inmate to herself, or four-point restraint in which an inmate is strapped down by bindings on all four limbs. Once restained the woman is usually left in seclusion.

Every move a person makes from morning to night can be, and often is, controlled in an institution. Not only through drugging but also through regimentation, observation by staff, and through the privilege system whereby rights are taken away and later given back for "good behavior" as privileges. Good behavior usually means obeying staff, not doing things considered strange, and not showing anger. In fact, "good behavior" *is* institutional behavior, docile behavior. Gradually, as an inmate conforms, she is allowed contact with the outside in the form of letters, calls, visits, walks, or the ability to get off the ward to smoke or shower. This conformity is called "getting well."

Medical Model

One of the reasons that there are not many laws to protect the rights of inmates is the prevalent concept that what is being done in mental institutions is handling specific problems not unlike medical problems. The phrase "medical model" refers to these comparisons, made by professionals and lay people in the "mental health" field, between physical illness and "mental illness".

The medical model holds that physical illness and "mental illness" are comparable, and that both are specific problems which have a specific cause and can be "treated" with a specific intervention, usually drugs.* According to this medical model, a troubled person is "sick" and therefore needs the care of a "doctor". "Mental illness," it is believed, has recognizable "symptoms," and can be "diagnosed," "treated" and "cured".

People who do things we do not understand or agree with are simply that. Being able to call a person "sick" puts a comfortable distance between the "normal" people and the "crazy" people — until the

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*Physical medicine as we know it suffers from the same problem — that of zeroing in on one symptom rather than socio-economic causes and than attempting to remove the symptom, often by the use of drugs, without necessarily removing the cause.

day when the "normal" people step out of line and get labelled "crazy" themselves. To use the word "sick" in describing an individual whose behavior disturbs us is to perpetrate an abuse against that person's integrity. If the forces of psychiatry are then called in to alter the person's behavior, the person's freedom is violated as well.

The use of the medical model serves to mystify people's pain, and to create the impression that only professionals are capable of understanding that pain. It may confuse people in institutions who feel angry and abused and are constantly being told that it is for their own good and that the "doctors" know what they are doing. Friends and relatives of inmates often buy into the lie, having their loved ones committed against their will.

In these ways, it has become difficult for *anyone* to share subjective experiences of an unusual or frightening nature, for fear of being labelled "sick". It then becomes doubly difficult for psychiatric inmates to even recognize that they share similar problems and a common oppressor, let alone find collective solutions to their problems.

Many people do not understand the inherently oppressive nature of the medical model of "mental illness" and involuntary "treatment". Some people who are committed to working for social change fail to see the basic connection between psychiatric oppression and other forms of oppression — fail to see that the institution of psychiatry is part of the very system we are all fighting.

Women and Psychiatry

A large part of the professional attitude that women are inherently less "mentally healthy" than men can be traced back to Freud who legitimated the belief that women experience greater difficulty than men in resolving the issues of psychosexual development. Freudian theory, which continues to shape much of current psychiatric thought, maintains a traditional view of the "normal" woman as wife and mother. Women are viewed exclusively in terms of our (hetero) sexuality and reproductive function; other aspects of our lives and personhood are either ignored or seen as less significant than our psychosexual development. For a woman to attempt to assert her independence or autonomy, to reject marriage or motherhood, to be a Lesbian or to begin to take control of the circumstances of her own life is seen in the Freudian view, as evidence of a "masculinity complex."

Though much of Freudian theory has fallen into disrepute, clinicians in general still view women as less "healthy" than men. In a now-classic study by Inge Broverman and her associates in 1970,(7) it was found that clinicians' concept of a mature adult was identical

Ellen Shub

"Medication is for the sick, not the proud."

to their concept of a mature man, but their view of a mature woman was quite different. She was more dependent and passive, and less assertive and adventurous than her male counterpart.

Professional views of women's "mental health" are bound by sexist bias. For members of the psychiatric establishment, a "normal," "healthy" woman is a "feminine woman", one who does not necessarily develop or use the full range of her talents, and one who is less than an autonomous, independent, strong individual. Women who deviate from acceptable standards of behavior are "sick". This is a prime example of science being used by members of the dominant class to justify their biases. It leads to subsequent oppression and punishment of those who do not conform to their limited notions of what constitutes "healthy" behavior.

What these views mean for women in institutional settings, whether psychiatric or "correctional" is that, in order to gain their freedom, they often must adopt the pretense (if not the reality) of "feminine", "ladylike" and therefore "healthy" behavior. Those who refuse to do so are punished in the name of "treatment" and those who deviate markedly are sent to even more controlled settings and places like the proposed Worcester unit, where, what real needs they may have for emotional support and help in a time of crisis will not even begin to be addressed.

Given this framework, it is not difficult to predict which women will be sent to the proposed Worcester

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**"MENTALLY RETARDED" WOMEN
AND THE WORCESTER UNIT**

From 1976-1977, the Coalition was told that no women from the state schools for the mentally retarded would be sent to the proposed unit. Then, in January 1978, suddenly *45%* of the women being screened for the proposed unit were being drawn from those state schools and institutions. It became clear to us at that point that our accusations against the Department of Mental Health were true: that the proposed unit, if opened, would indeed be a dumping ground for *all* state institutions. Furthermore, the reasons for "mental retardation", like the reasons for "mental illness" are socially defined and can therefore be extremely vague. We can only speculate as to how many women are institutionalized today as "mentally retarded" who may have been early victims of child abuse, neglect, repressive school and learning environments. The fact remains clear: that DMC and DOC plan to combine women prisoners, psychiatric inmates, and women labelled mentally retarded — groups with extremely diverse needs — into one catch-all "therapeutic environment" where each woman will not only take on the "violent" label, but will also take on the labels already assigned to other women around her.

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unit. They will be those who DMH and DOC find troublesome for any number of reasons. They will be women in institutions who demand their rights and who fight back when those rights are violated; women who are justifiably angry at the condition of their lives both outside and inside the institutions in which they are incarcerated. They will be women who direct their anger at others, striking out in pain and rage and self-defense, and also women who turn their anger inward, hurting themselves because they have been belittled, brutalized, and have led overwhelmingly impoverished lives. They will be poor women, Black women, Hispanic women, Lesbians — any woman who lacks sufficient money and privilege to escape incarceration by the State.

Currently, the popular media is playing up the supposed presence of the "new, violent woman." Professional journals have taken up this new "problem" as well. Many theorize that women's violence is increasing as a result of the Women's Movement. As women become "liberated," so the theory goes, they will begin to adopt "male" patterns of violence and criminality. This theory ostensibly has been used to justify the construction of new maximum security settings for women such as the proposed Worcester unit.

A class of women will be created to fill the "need" for the smaller units being proposed all over the country. In 1972, it was estimated by the Massachusetts Department of Mental Health that there might be 6-10 women a *year* in need of the proposed unit. At present, the current project director is engaged in consultation concerning approximately 50 candidates for the proposed unit. In 5 years, the mere notion that a unit might someday exist has increased the number of women labelled "violent" by 500%! We have every reason to believe that the expansion will continue.

Feminists recognize the notion of the "new violent woman" for what it is: a media creation which is part of the growing backlash against the Women's Movement. The evidence shows that the rate of violent crime by women is not increasing.(8) Yet often we see stories in the press of women's violence being on the rise.

These reports serve as reminders to women of what can happen to them if they "go too far". In the late 1800's, when women's education became an issue during the First Wave of the Women's Movement, the

newspapers in this country were full of stories of women who fell into "wantonness, sin and destruction" as a result of education.(9) The similarities between those stories of the 1800's and today's "violent women" stories are striking.

It is not insignificant that the perpetrators of the proposed Worcester unit try to dismiss the vocal opposition to the unit by labelling us "a bunch of dykes." Women who do not conform to "acceptable" standards of behavior have long been called Lesbians. Angry, vocal, assertive women have always been perceived as threatening to those who would maintain the status quo of male supremacy. As women begin to organize and chip away at the system which oppresses us, those with a vested interest in maintaining that system will continue to throw out the labels: "dyke", "crazy", "wild", "violent". Labelling takes one aspect of a woman and makes that her entire identification so that everything she says or does can be discounted. This labelling happens on some level to all women who step out of the "female" line. Our response to these labels is to turn them around and use them for positive self-identification. Rather than responding by denying that we are angry, we can say sure we're angry and it's ok to be that way.

While increase of violence committed by women is a myth, the increase of violence against women is a stark reality. Physical violence against women, in the form of battering, rape, and assault continues to rise. Psychological violence, sexual harassment, violations of women's integrity, have always been our daily reality. Institutional violence in psychiatric institutions, in prisons, in schools, and in the media is increasing.

The proposed Worcester unit is an example of institutional violence at its most insidious. Designed to be a maximum security, behavior modification unit for women already in institutional settings, it will be a dumping ground for women who refuse to be broken, women for whom "all else has failed" in altering their "deviant" behavior.

Prisons and the Worcester Unit

The Worcester Unit, from both the physical plans and from the Determination of Need Application, clearly will become a prison. And not unlike psychiatric institutions, prisons are the easiest way to isolate, warehouse, and remove poor people, angry people, people trying desperately to survive in a system that has no economic use for them.

Historically women have rarely been imprisoned for violent crimes. The overwhelming majority (85%) of women in prisons, jails, and awaiting trial (15,000) are imprisoned for acts directly related to economic survival: prostitution, larceny, forgery, shoplifiting, receiving stolen goods, drugs.(10) These economic
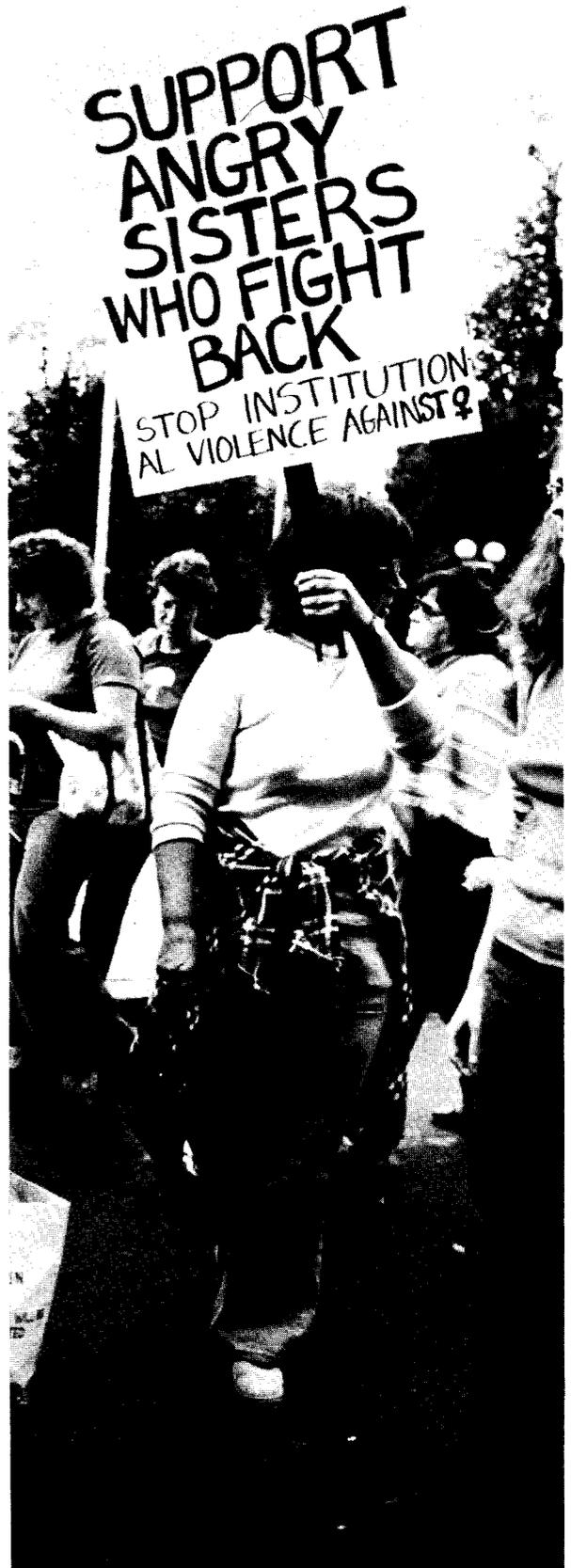
"crimes" which are directly related to the economics of survival form the basis of a no-win situation for most women who are imprisoned. A woman who has been imprisoned for prostitution and larceny, who has no job skills, two kids to support, no apartment to live in, no job, and $50 in her pocket when she leaves prison is asked to survive in an impossible set-up without going back to her network of support from the street life which may well be the only network she knows. Yet, there is a move on in this state and throughout the country to build more cages. In 1978, the Massachusetts legislature passed a budget appropriating nearly $1 million to "renovate" the state prison for women. This included $300,000 for a new security system in the women's living space and over $600,000 to substantially change the structure of the maximum security wing. Most prison budgets in the country spend less than 10¢ of every dollar for vocational and educational training, health care, and human needs. If all potential cell space in that wing is renovated, there will be room for 40 maximum security cells — enough to cage approximately 50% of the women at a time.

Massachusetts can now boast of a full range of prisons from maximum-minimum security to self-policed mini-prisons set in the communities (but not controlled by those communities). In the mini-prisons, called pre-release centers, the threat of being shipped back to the tighter institutions keeps prisoners in line and in constant fear. A whole step system for men exists within each separate prison as well as within the entire system and culminates in Bridgewater. Without the proposed Worcester unit the system is incomplete for women. Clearly the struggle against the proposed Worcester unit and the new max cells at the prison are one and the same.

"No Rights for Locked Women"

One of the strategies developed over the past two years by the Coalition has been to oppose the opening of the proposed unit on the grounds of civil liberties violations. Upon close examination of the DMH application, we find that there are no commitment, transfer, admission, or discharge standards. Also, women prisoner/patients will not have the right to refuse "treatment", which can range from drugging to psychosurgery. There are no guarantees of regular visiting hours, outside recreation, mail "privileges", and many other things which keep a woman in contact with the outside world.

There are many behavior modification units across the country which, although some have existed for only a short while, have given reason to believe that it is impossible to preserve people's civil liberties in a locked and forced environment despite the best precautions

and intentions. In Massachusetts, there were in 1975 alone three successful civil rights suits against Bridgewater, a "model" for the proposed Worcester Unit. Still pending here also are the series of constitutional claims of the Boston State Hospital inmates in *Rogers* v. *Macht,* which center on the issues of use of seclusion, forced drugging, and other forced "treatment".

Many have responded to the issue of civil rights for locked women in the proposed unit. Peggy Weisberg of the National Prison Project of the American Civil Liberties Union, a Washington D.C.-based group that has researched many such programs, has said: ". . . we can only conclude that the proposed Worcester Unit is essentially a behavior control unit for women prisoners . . . the purpose of which is to make a person less disruptive and more manageable when she returns to Framingham . . . it has been proven time and time again that these programs simply do not work." Here in Massachusetts, the Board of the Civil Liberties Union unanimously concluded that the proposal for the Worcester unit "cannot be drafted in a form to withstand constitutional attack".

A similar conclusion occurs to nearly everyone who seriously considers the civil rights issues involved in the proposed unit. The totally locked situation by itself is a violation of constitutional rights.

Where Do We Go From Here

At a time when the state is cutting back on all social services and simultaneously expanding the prison construction budget, progressive people have no choice but to challenge the trend of delivering "treatment" rather than social justice. Delaying or preventing construction or proliferation of small behavior modification units is in itself important and necessary work. Much of the Coalition's time is taken up with this struggle directly: lobbying, working within the Determination of Need process, mobilizing opposition to speak at and attend public hearings, writing articles, doing public educationals. We know that these small units will increase the repressiveness of the present system; they would further isolate women already incarcerated, women already subject to the behavior modification, the degradation, the forced drugging which is the standard practice in all psychiatric and prison facilities.

Ultimately, then, our goal is to dismantle the whole violent system. Our vision demands a strategy that includes four aspects: anti-institutional work, support work for women already incarcerated, support work for genuine alternatives for people in crisis or distress, and, finally, personal practice to overcome the violence that pervades our daily lives. We need to participate in the expansion of a new culture, a freedom/struggle culture.

Even as we are working in a larger movement for social change, our daily lives are still very fragmented. It

is a fact of our lives that as individuals we simply cannot respond adequately to the many who are in need of support. The needed networks of support do not yet exist. Our short-term strategy, therefore, must include support for and development of additional transitional shelters.

Built into the capitalist system is the tendency to create sickness, to turn the natural vitality of the body and spirit into a commodity. We may come to accept suffering and our powerless positions within the system as inevitable. Vast education, health, treatment, and corrective industry is maintained to treat "problems" within the individual and to suppress any spontaneous realization of the material and political connections in individuals' distress. We all live at a pace of life that makes it hard for us to feel beyond what we have been taught. The rage and frustration that we feel is expressed in ways that serve to maintain the system: domestic violence, competition, self-hatred.

In order to transform society, then, we have to be involved in transforming ourselves as well. We have to generate ways of supporting each other emotionally in the work we do — a hard task when we carry at least a double load of work, political and rent-paying. We have to create safe spaces for ourselves to talk about our fears and frustrations, exploring alternative ways of healing, experimenting with new ways of expressing ourselves, comforting each other, renewing our strength for the struggle without slipping outside of it. We need to be involved in a process of cultural self-analysis in order to develop new forms for cooperative group work to overcome the individualism we were raised on. This is not

easy. The inhibitions we were trained in run deep: self-love and other-love is antithetical to commodity accumulation.

Women in emotional crisis, even women who are suicidal or assaultive, do not need to be imprisoned, drugged, or subjected to shock and behavior modification. These "interventions" only remove us further from our pain and confusion. Women in crisis need programs which offer support, feminist, non-racist counseling, vocational and educational opportunities and much more. These women, like all of us, have been brought up in and put down by a racist, classist, and male supremacist society. We must recognize the role that powerlessness and oppression play in the lives of all women. Women need to be empowered, to change our self-image, to demand, and to be encouraged to take control of our lives and responsibility for our actions. We need our strength to survive in and help change the very society that exploits us.

The Women's Community has set up shelters where women are safe from physical assault and have the support to take new directions in their lives. The women of these shelters recognize that emotional crisis happens within a political, social, and economic context. Women who came to the shelters, therefore, are not blamed for their crises, they are supported through them. These shelters for battered women, or for women with alcohol or drug histories were not created specifically as alternatives to the mental health system, but as centers for real support for women in crisis.

There are very few alternatives to psychiatric institutions. The Elizabeth Stone House in Boston and the

Vancouver Emotional Emergency Center (VEEC) in British Columbia are examples of alternatives that have successfully, without the use of medical "treatment" supported people through emotional crisis.

In her book, *On Our Own*, (New York: Hawthorn, 1978), Judy Chamberlain describes her own and others experience at VEEC. VEEC was based on the knowledge that all people have emotional crises. The roles of helper and person helped could be interchangeable. Staff used VEEC at crisis times in their own lives, and people who had lived there also became staff. All decisions were made by residents *and* staff. Staff were available for conversation and support at all times, even in looking for an apartment or finding a job. Above all, people were free to leave whenever they wanted. As soon as they felt they could, they set goals for their stay. These could be revised by the individual at any time.

We all need to be able to vent our anger about the many injustices we have suffered: healing cannot happen when the expression of anger brings down more punishment. VEEC provided the necessary combination of a warm and caring environment, safe space for the expression of anger and pain, and time away from the pressures of daily life, through which people heal themselves.

While we generate support for transitional residences, we need to remember the women that are already locked down, and find ways of supporting them in the here and now. This support can take many forms — bringing in fresh and nutritious food, participating in sports or classes, entertainment, regular visits, creating a network of support for families of prisoners and inmates, driving children out to visit their mothers. As we get stronger as a Movement, we can begin to envision more militant actions on back wards — actions taken with the support of psychiatric inmates and prisoners, and progressive (always overworked) staff within the institutions.

Over time we will create a broad network of people who have suffered in the State's warehouses or have been touched by alternative methods of handling crisis. But the ripple effect of our cultural work can not overcome the punishment-and-death culture until the extension of the prison State is dismantled. The network of communities, families and friends of prisoners and psychiatric inmates, cultural workers, and advocates of alternatives will sooner or later feel empowered enough to demand that our resources go into truly human services.

In the meantime, we must battle the State to a standstill on each new prison — "psychiatric" or "correctional" — that it dares to propose.

For further information, write: *The Coalition to Stop Institutional Violence*, c/o The Cambridge Women's Center, 46 Pleasant Street, Cambridge, MA 02139. □

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1. Quoted from the Department of Mental Health's application for a Certificate of Need for the proposed Worcester Unit. This application is available to the public at the Determination of Need Office, Room 925, 80 Boylston Street, Boston, MA 02116.

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3. Department of Mental Health Admission Statistics, 1975.

4. See "Epidemiology of Tardive Dyskinesia Part I", Pineau, R. et. al., *Diseases of the Nervous System*, Volume 37, No. 34 April, 1976. For an explanation of side effects of Tardive Dyskinesia also see *Consumers Guide to Psychiatric Medication*, by David Briggs, Project Release Booklet, New York, 1975.

5. One example of this profiteering is the Smith-Kline Drug Co., whose psychiatric drug sales have doubled in the past five years (*Annual Report*, 1977). Psychiatric drugs account for 20% of all sales.

6. We refer readers to *The American Health Empire*, by the Health Policy Advisory Committee, New York; Vintage Books (Address: 17 Murray Street, NYC) and to *Prognosis: Negative*, by Kotelchuk of Health PAC for an analysis of the profits of drug companies in relation to and as part of the corporate structure.

7. See Broverman, Inge, et. al. "Sex Role Stereotypes and Clinical Judgements on Mental Health", *Journal of Consulting and Clinical Psychology*, Vol. 34, No. 1, 1970, pp. 1-7.

8. In 1960, women constituted 10% of all arrests for violent crime in this country. Fifteen years later, women still accounted for 10% of all arrests in violent crimes. Source: Uniform Crime Reports, 1975, Washington, D.C.

9. There are several books that have been written about the backlash in the late 1800's against women becoming educated. For a further review of this, we refer the reader to: *I'm Radcliffe! Fly Me! The Seven Sisters and the Failure of Women's Education*, by Liva Baker, New York: MacMillan and Co., 1976; *Peculiar Institutions*, by Elaine Kendall, New York: G.P. Putnam and Sons, 1975; and *Miss Marks and Miss Wooley*, by Anna Mary Wells, Boston: Houghton-Mifflin, 1978.

10. This quote is taken from a 1975 letter written by a New England psychiatrist to the then Director of the Prison Health Project regarding plans to find a place to house "violent" women in Massachusetts institutions.   (Coalition files).

resources

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

Biological and Medical Aspects of Race, N.O. Calloway, M.D. and O.N. Harris, Ph.D., American Publishing Company (2909 Syene Road; Madison, Wisconsin 53713), 1977, 370 pp., large format, with a (political) glossary, references, sample questions, and an index. $13.00. Both authors are with the Department of Afro-American Studies/University of Wisconsin (Madison). "This text is written for a course entitled Biological and Medical Aspects of Race. The course is designed to give the student some casual ideas of the interdependent roles of genetics, disease, and culture in the development of ethnic groups. We explore the role of prejudices, fears, legends, and religion in this interplay of forces which maintains polymorphisms in human populations. Most of our discussions deal with the Afro-Americans, since they are the paramount emergent ethnic group in this country. Our emphasis on this group relates to the fact that the course here at the University of Wisconsin was born from the campus unrest of 1968-1970 in an attempt to teach the black student and all other students, for that matter, just who they really are."

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Marx and Engels on Ecology, Howard L. Parsons, Greenwood Press (51 Riverside Avenue, Westport, Connecticut 06880), 1977, 262 pp., $16.95 (h), with a 31 page smashingly annotated bibliography. In his introduction (118 pages of it), Parsons includes a brief survey of the historical background of the thoughts of Marx and Engels, an exposition on their basic position on ecology and on their critique of capitalistic ecological policies. He presents the common criticisms of the Marxist position on ecology, answers these criticisms, and treats the problems of transition from capitalistic to socialistic ecology.

Women and Health. Several important titles are to be mentioned. *Women and Health Care: A Bibliography with Selected Annotations*, Sheryl K. Ruzek, Program on Women; Northwestern University (619 Emerson Street; Evanston, Illinois 60201), 1976, 76 pp., $3.50. *The Hidden Malpractice: How American Medicine Mistreats Women*, Gena Corea, Jove Publications/Harcourt Brace Jovanovich, 1977, 350 pp., $1.95 paperback. *Nuestros Cuerpos, Nuestras Vidas: Un libro por y para las mujeres* (Spanish edition of *Our Bodies, Ourselves: A Book By and For Women)*, Boston Women's Health Book Collective, 1976, 382 pp., $2.00 large paperback, available from Spanish Edition c/o Marianne LaLuz (161 Wachusetts Street, Jamaica Plain, MA 02130). *Women's Work, Women's Health: Myths and Realities*, Jeanne Mager Stellman, Pantheon Books/Random House, 1977, 263 pp., $3.95 paperback. *Workbook On Sterilization and Sterilization Abuse,* Ad Hoc Women's Studies Committee Against Sterilization Abuse, 1978, 51 pp., $1.75, available from Women's Studies/ Sarah Lawrence College (Bronxville, NY 10708). *American Midwives: 1860 to the Present*, Judy Barrett Litoff, Creenwood Press (51 Riverside Avenue; Westport, CT 06880), 1978, 197 pp., $15.95, massive bibliography. *Woman Doctor: The Internship of a Modern Woman*, Florence Haseltine, M.D., and Yvonne Yaw, Houghton Mifflin Company, 1976, 337 pp., $8.95.

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Victims of the Miracle: Development and the Indians of Brazil, Shelton H. Davis, Cambridge University Press (32 East 57th Street, New York, NY 10022), 1977, 205 pp., $15.95 (h), $5.50 (p). The author is the Director of the Anthro-

pology Resource Center. "The central contention of this book is that the massive amount of disease, death, and human suffering unleashed upon Brazilian Indians in the past few years is a direct result of the development policies of the military government of Brazil. I analyze the human and ecological consequences of neocapitalist development (i.e., the "economic miracle") in the Amazon region of Brazil."

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People & Energy (Subtitled: News of Citizen Action on Energy and Appropriate Technology) is published by the Citizens' Energy Project, 1413 "K" Street, N.W., 8th floor, Washington, DC 20005. In an easily readable format they cover the various aspects of energy conservation, nuclear power opposition, energy alternatives, etc. Each issue has a resources section to keep folks updated on the newest materials that are available. Since articles making the connections between energy problems and national minorities are few and far between these days we want to point out an article in their March 1978 issue entitled "Native Americans and Resources Development: Third World Brought Home." *People & Energy* is published monthly, $10/year.

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Anti-Nuke Diary. The *Big Red Diary 1978* was about the politics of food. Now the same group has published the *Big Red Diary 1979* and it is about the politics of nuclear power. Published by Pluto Press (England), available from Southwest Book Services (4951 Top Line Drive; Dallas, Texas 75247), $3.50.

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Nuclear Power and the Black Liberation Struggle, Kalamu ya Salaam, published as a pamphlet by AHIDIANA-Habari (PO Box 3472, New Orleans, LA 70177), $0.50. It was originally published in the July/August 1978 issue of *The Black Scholar*. AHIDIANA is a New Orleans-based Pan-Afrikan nationalist organization that actively supports the struggle against nuclear power.

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Medical Care and Socialism: Problems and Prospects in Tanzania

by Walter and Gail Willett

Tanzania is an East African country of approximately 16 million people known to many Americans only as the site of Mount Kilimanjaro, Serengeti game park, and the movie "African Queen." The country was a German colony until World War I and subsequently became a British protectorate called Tanganyika until independence in 1960. In 1964 the Arab Sultan of Zanzibar was overthrown in a popular uprising, and shortly thereafter the island of Zanzibar joined the mainland in a federation which became known as Tanzania. Swahili is the mother tongue of Zanzibar and the coastal areas. Since Independence, it has become the language for primary education and official use and is thus widely spoken throughout the country.

Tanzania has a wide variety of environments ranging from a hot, humid coastal area to vast arid plains and moist, cool and fertile mountain ranges. Its population is one of the least urbanized in the world; less than 10% live in towns or cities. The vast area with a low population density has made the delivery of health and other social services difficult. Partly for this reason, a national villagization program has been carried out within the past several years. Mass movements of the rural population have occurred so that virtually the whole rural population now lives in villages. It has been the intention that production in these villages be on a communal basis, but this has been realized only to a variable degree, largely depending on local traditions.

Internationally, Tanzania has been in the vanguard of support for the liberation of Southern Africa, and most African liberation movements have had their headquarters in Dar es Salaam at one time or another. While unequivocally supporting the liberation movements, Tanzania has sought to maintain friendly relations with both East and West. Of note are the important contributions China has made to Tanzanian development including the construction of the Tanzam Railway linking Dar es Salaam with land-locked Zambia.

Since 1967 Tanzania has committed itself to a socialist form of development. This article deals with socialist development in the health sector and attempts to examine progress to date as well as contradictions that have arisen in the course of this development.

Tanzania faces health problems typical of most Third World countries. The top three causes of death are pneumonia, measles, and diarrhea. Malaria, malnutrition, intestinal worms, tuberculosis, and leprosy are also very common. 16 percent of children die before the age of one. In spite of this, a high birth rate causes the population to grow at a rate of nearly 3% a year.

What distinguishes Tanzania from most other countries with these problems is a stated policy of socialist development, including a commitment to improving the health of all the people.[1] This paper will describe the development of health services in Tanzania and offer some subjective observations of their function at present.

At the time of Independence in 1960 Tanganyika had fewer than 20 trained doctors of its own and a small number of medical auxiliaries. Government health services were concentrated in several racially segregated urban hospitals, of course with a disproportionate share of facilities for Europeans. Mission hospitals in rural areas accounted for almost half the number of beds nationally but were concentrated in a few more developed areas of the country.[2] The emphasis in both government and mission health services was overwhelmingly on curative medicine, rather than public health, and thus did little to alter the pattern or incidence of disease.

The main economic efforts of both German and British concentrated on large agricultural estates, such as those which produced sisal (from which rope is made), and required a large mobile labor force. Poll taxes were created to force male workers to leave their village subsistence agriculture and to work on these es-

tates in order to earn money and pay their taxes. Disease prevention programs were largely related to keeping this labor force healthy. However, the effect of this economic pressure was often to remove needed labor from the village agricultural system, causing a deterioration in the nutritional and health status of mothers and children left behind, to say nothing of the social disruption and disintegration also produced.(3) In areas where male labor was not siphoned off, the same economic forces caused a replacement of subsistence farming by cash cropping, with similar damaging effects.

The newly independent government initially emphasized the training of doctors and did little to change the basic character of health services, which had very minimal impact on the health of the majority of Tanzanians. In 1967, under the leadership of President Julius Nyerere, Tanzania re-examined the direction of its development, and decided that the current direction was not likely to benefit the majority of the population.(1,5) With support from workers and peasants, the principles of socialism and self-reliance were declared. In the initial phases the controlling sections of the economy such as banking, insurance companies, and import-export trade were nationalized. Health and education became the major foci of the national effort.

### Translation of a Socialist Health Policy into a National Program

Given a commitment to provide health services to all the people, over 90% of whom live in rural areas, a program was developed to provide the facilities and train the staff. The total economic resources available in Tanzania for this task are small — on the order of 3 dollars per person annually. It became obvious that the

health services must be based close to the people, and be delivered primarily by auxiliaries.(4,5)

Under this program the primary unit for both preventive and curative services is the dispensary, serving 5-10,000 people. This unit is headed by a Rural Medical Aid who is a primary school graduate with 3 years of training. A Maternal Child Health Aide, who has 18 months of training, provides routine immunizations and nutritional supervision for children as well as obstetric and family planning care for women. A Health Auxillary, to supervise sanitation and preventive programs is also associated with the dispensary.

The next largest component of the health system is the Rural Health Center, which is headed by a Medical Assistant who has had 3 years of training after secondary school. The Health Center serves a population of about 50,000, has 20-30 beds and cares for simple inpatient problems as well as offering outpatient treatment and basic preventive services. District, Regional, and National Referral hospitals are headed by doctors and deliver primarily inpatient curative services.

Tanzania plans to have the entire system completed and staffed by 1980 and seems to be keeping fairly close to schedule. Almost all of the approximately 2000 planned dispensaries and more than half of the health centers have been constructed and are functioning. At present approximately 90% of the population is within walking distance of a health facility. Although often using make-shift buildings and nearly always short of teaching staff, the training schools for health workers are operating and graduating large numbers each year. Fully trained Rural Medical Aides now staff approximately half the dispensaries, although informally trained health workers staff the others. Maternal Child
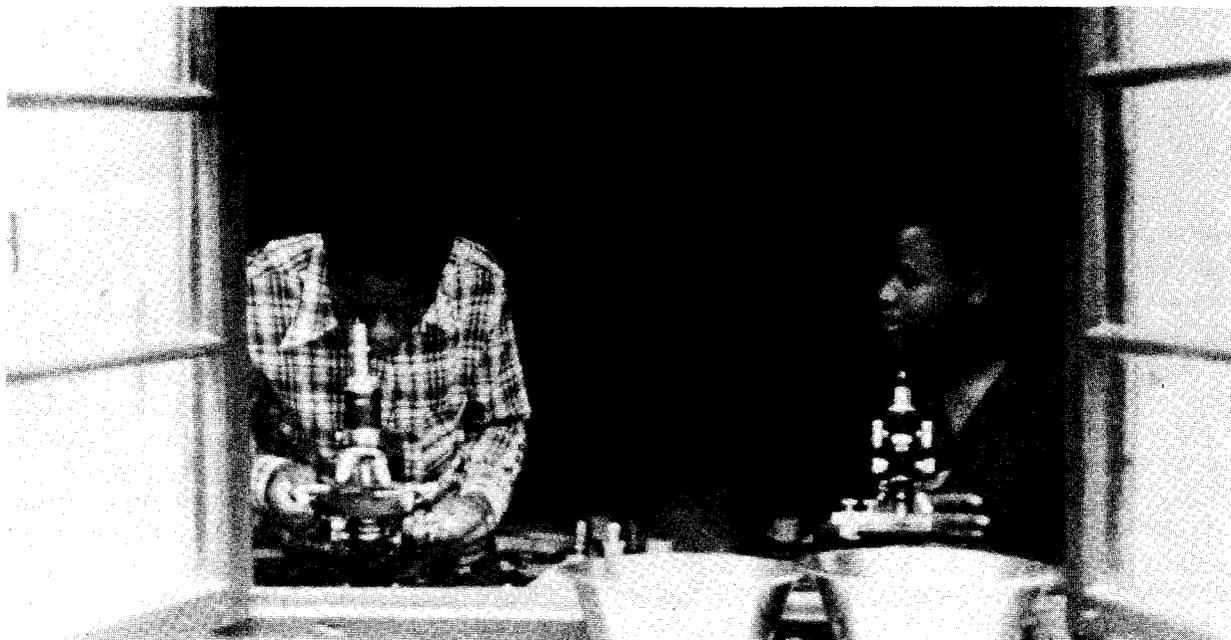

Walter and Gail Willett

Health Aides and Health Auxiliaries have been graduating from training schools for the past two years, and by 1981 are expected to be sufficient in numbers to staff all dispensaries. The ability of the medical auxiliaries is impressive and their service, particularly in the area of Maternal Child Health, is extremely popular and growing rapidly every year.

Even when the system is completed it will probably not be able to provide for all the basic health needs of the population. Largely for this reason another level of health worker has been created — the village medical helper (VMH) whose function is similar to, and probably largely inspired by, the Chinese "barefoot doctor." This person is chosen by his or her village and receives 3 months training. Upon return to the village, the VMH treats simple problems and carries out basic health education. This work may be the VMH's contribution to the village communal efforts, or the village may choose to compensate him/her otherwise.

The Role and Education of the Doctor

Except in the case of a few medical specialists in the referal hospitals, the role of the doctor in Tanzania goes far beyond the diagnosis and treatment of illness in individuals. Virtually all medical graduates are employees of the Ministry of Health, and most serve as District or Regional Medical Officers. As such, doctors must assess health priorities within their districts or regions and allocate the scarce resources accordingly. This is done in conjunction with District and Regional political leaders, as well as the district officers of education, agriculture, water supply, and other departments. In addition, a doctor will supervise large numbers of Rural Medical Aides, Medical Assistants and other auxiliaries. S/he must monitor their work, be available for consultation and is normally in charge of their continuing education. This requires long hours spent traveling over bumpy, dusty roads, usually in dilapidated Land Rovers, to visit the widely scattered dispensaries. Most doctors also have considerable responsibility for the basic education of one or more cadre of health workers, as many district hospitals will have attached to it a training school for nurses, rural medical aides, or other health workers.

The education of doctors in Tanzania therefore involves considerably more than the usual medical education which focuses on disease and its treatment. The single medical school is located in Dar es Salaam and was started 15 years ago. It currently graduates 50 doctors per year. Public health training, including extensive field work, is incorporated in all 5 years of medical education. By the time a student graduates s/he has worked in villages, dispensaries, health centers, and district hospitals and knows the difficulties of these jobs first hand.
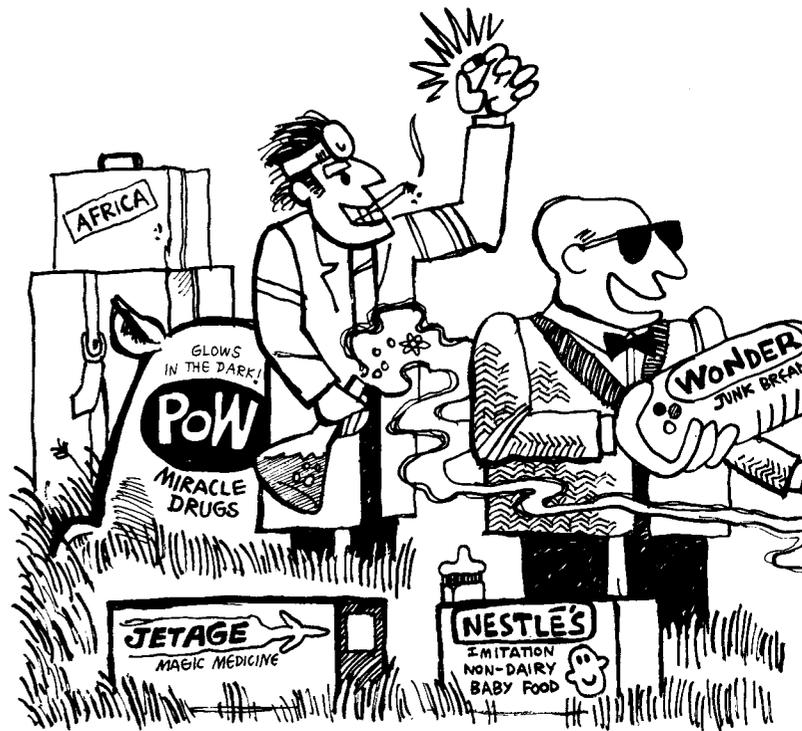
S/he has also personally participated in village nutrition and infectious disease surveys and thus has first hand experience in measuring the prevalence of common health problems as well as relating them to social and environmental factors. Participating in the education of these students for 3 years was a most rewarding experience as they were almost without exception serious and hardworking. Public health has, world over, been traditionally the least popular of subjects for medical students, and Africa has in general been no exception. Although it is certainly not the favorite course of many Tanzanian students, virtually all have realized its central importance. Most encouragingly, public health has become the most popular program for postgraduate study in Tanzania.

Political Consciousness and Professionalism

It is obvious that the transition from a capitalist medical system, where a doctor sells the service of treating disease, to a system where the doctor's primary role is to improve the health of the population which he or she serves, requires a considerable shift in political orientation. Political education, emphasizing the development of socialism in East Africa, is therefore a part of normal medical training. However, virtually all medical teachers are products of a traditional Western capitalist medical system, and it is inevitable that some of the values associated with this system are passed along in the education process. Although some students might, given the choice, select the considerably more lucrative role of private practice, they all understand the rationale

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and necessity of the present health policies.

After graduation Tanzanian doctors are required to serve with the government health service for at least 5 years, the first two of which must be in rural areas. It is notable that very few doctors trained in Tanzania leave their country to practice abroad, as is the case in many developing countries.

Political education is also part of the training of all medical auxiliaries. Most of these schools have also implemented projects whereby the students produce a large portion of their own food. The political orientation emphasizes the dignity and worth of all individuals no matter what their type of work may be. Strong political committees exist in virtually all hospitals and insure that workers are treated with respect by doctors and administrators. However, the British medical legacy of authoritarianism on the part of doctors toward both patients and nurses is still in evidence. This medical authoritarianism is often re-enforced by traditional sex roles, especially in the case of nurses, and contributes to a working relationship that, although improving, is still less than satisfactory.

The authoritarian medical tradition together with the pressure of time (in one urban dispensary a survey showed patients were seen an average of 45 seconds each) also leads to a health worker-patient relationship that is usually far from fully developed, and is not likely to be so for some time. It is hoped that the further development of maternal-child health aides at the dispensary level and village medical helpers will facilitate communications relating to health matters.

Conflicts with International Capitalism and Class Contradictions within Tanzania
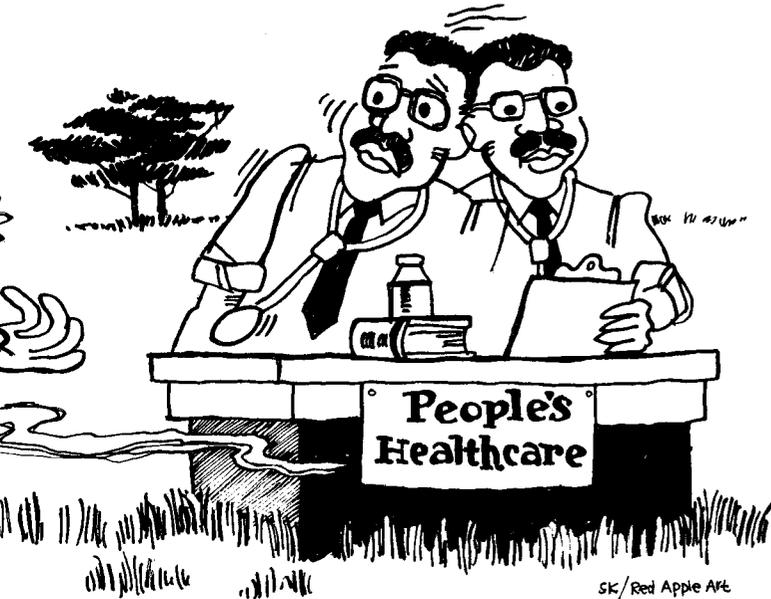
Clearly the health program that Tanzania is implementing, which attempts to use the small national resources to maximize the health of the people, is in conflict with the traditional capitalist health system which is mainly motivated by the profit in disease. One would hardly expect that such a change in orientation could occur without conflicts and inconsistencies, some of which are described here.

Although Tanzania has attempted to gain control over the important aspects of its economy, it still operates within the international capitalist system. This is seen very clearly with respect to the drug industry.(7) The overwhelming majority of illnesses that come to medical attention in Tanzania are infectious diseases that can be treated with simple, safe, and inexpensive medicines.(8) For example malaria, diarrhea, and pneumonia (among the most common reasons for seeking medical advice) are best treated with chloroquine, a salt and sugar solution, and penicillin respectively. However, this would not be profitable to the large drug companies in America and Western Europe who have employed more than 140 representatives in Tanzania to push their newest, least proven, and most expensive products. These drugs are marketed in Third World countries with claims not allowed in the U.S. and without warnings of life-threatening complications required of the same manufacturers in their own countries. For example, aminopyrine and dipyrone are minor pain-relieving drugs that may cause fatal suppression of white blood cells and are licensed for use in the United States only in patients with terminal malignant disease. In Africa they are sold in 31 different preparations at a cost of up to 150 times that of aspirin and promoted for the relief of a myriad of minor symptoms.

The amount spent promoting such drugs far exceeds the amount spent on medical education. The predictable result is that large amounts of inappropriate drugs are purchased, while penicillin and other life-saving drugs are often not available in dispensaries.

For instance, our medical students discovered that one district had ordered a huge amount of dihydro-streptomycin, costing one third of the district drug budget. The drug is promoted as an antidiarrheal agent but has no demonstrated benefit and may well be harmful. An effective treatment is a salt and sugar solution. Tanzania, with the help of China, has started producing and compounding its own basic drugs, but this has of yet had little influence on the activities of the multinational drug companies.

Another exploitative activity of international capitalism has been the well-known promotion of bottle feeding by Nestle's and other companies. Artificial feeding,

especially in an environment where strict hygiene is impossible, greatly increases the mortality of infants. Tanzania's state of "underdevelopment" has been advantageous in this instance in that strong traditions and lack of purchasing power ruled out bottle feeding except in a small minority of urban residents. Government policy now strongly emphasizes the advantages of breast feeding and the risks of bottle feeding. This has thus not become a large problem in spite of the efforts of infant food corporations.

A more complex issue has been class conflict in the determination of health priorities within Tanzania. The stated national policy which concentrates on the development of widely distributed dispensaries and health centers staffed by medical auxiliaries and emphasizes basic prevention services, is clearly in the interest of the country's workers and peasants. One might expect that the entire medical establishment and upper classes (although small and weak) would not voluntarily give up their perceived priorities, which consist of an emphasis on doctors providing curative service and modern sophisticated hospitals. (Ironically, most of these high technology curative services, such as coronary care units, have not been shown to affect health even in

developed countries. (9,10)) The result has been that,in spite of impressive development in rural areas, urban hospitals still receive a disproportionate share of the national resources, some inappropriate equipment (such as coronary care facilities) continues to be purchased, and the efforts of the multinational drug companies receive some local support.

National class interests were also reflected in the recent controversies regarding private practice. In 1976 the Minister of Health declared that private medical practice was inconsistent with the concept that there should be no profits derived from disease. It was also clear that, although private practice represents only a very small fraction of medical services, the government would in the long run have difficulty keeping doctors in its service when private practice offers the chance to earn up to ten times the government salary. The announcement of the Minister of Health that private practice would be eliminated was very popular as most people realized that private practice meant service for only a small minority of urbanites with money. There were, however, strong protests against this move from some members of the medical community and members of parliament. Subsequently, the Minister of Health formulated a policy whereby private practice would not

DRUGS AND HEALTH CARE IN MOZAMBIQUE

Sitting around a table piled high with therapeutics journals and bulletins — and lists of drug prices — Mozambique's Therapeutics Committee is producing a new, shorter list of drugs for the national health service. The current formulary, produced last year, lists 459 products by generic name. And its use is mandatory for subsidised health service prescriptions. But the list is still considered too long.

"Good therapeutics at the lowest price" is the national policy, according to committee head Professor Antonio Ruas. Where drugs are equivalent, the least expensive is chosen. But an attempt is made to include a variety of drugs, both to permit the health service to respond to changing price relations, and to ensure that second and third line drugs are available for most conditions. "In 90 per cent of cases of pneumonia, penicillin is OK. But you must have drugs available for the other 10 per cent," Ruas explained. For this reason, the committee feels that it will never get down to the 50 or 100 drugs considered basic in some quarters, or even to the 220 on the WHO essential drugs list (see *New Scientist*, 18 May, p. 442).

Health has been a consistent priority both of Frelimo during the revolution and of the new government. In July 1975, just one month after independence, all health institutions were nationalized and private practice banned. In November 1977, medicine was also socialised. Visits to a doctor now cost only about 25¢ and all hospital, preventive, and maternal care is free. Drug prices are more complex. Private drug sales are still permitted, although the health service now supplies more than half the drugs. A list of 50 essential drug products — for the most common transmissible diseases such as tuberculosis, malaria, parasites and leprosy, as well as basic antibiotics and antiseptics — are free to everyone. For other drugs, families earning less than $100 per month (95 per cent of the population) pay 5 per cent of the government's bulk purchase price. Higher income groups pay 25 or 50 per cent.

Mozambique is also studying traditional remedies. This policy is based on the experience of Frelimo in the liberated areas on the north of Mozambique before independence three years ago. "During the war, some traditional healers did help — curing illnesses and treating wounds. But others did not help. In traditional society, the witch doctor is an intermediary between man and the supernatural. Some of those people wanted to develop a similarly strong position in the liberated areas. So Frelimo decided it must fight obscurantism while using the true knowledge of the people."

Since independence, virtually all the Portuguese doctors left (Ruas is an exception) and have been replaced by foreign volunteers. In common with many developing countries, Mozambique does not have enough doctors and is training paramedical workers. Two groups of these will be able to prescribe drugs — medical agents, with six years of schooling and a two-year course; and medical technicians, with nine years of schooling and a three-year course. The agents will head rural health centres; 45 have been trained so far. The technicians will head rural hospitals; 63 have been trained so far.

Drug purchasing is the other area in which Mozambique has made a radical change. Each year, the government publishes its proposed drug order and invites countries and drug companies to bid on individual items. The colonial government also bought drugs annually through an international tender, but it was not open to socialist countries. This new policy has sharply increased the number of suppliers, which also change from year to year.

Quality control remains one of the major concerns of the Therapeutics Committee. Mozambique is setting up its own pharmaceutical industry and hopes by 1980 to have testing facilities that it can use to check both its own production and imported drugs. In the interim, however, it must trust to luck and reputation. A few low bids have been rejected because of fears about quality. And, in general, "we have more confidence in the socialist countries", according to committee member Carlos Marzagao.

Problems remain in the drug field. Drug company representatives still operate in Mozambique. They encourage doctors to prescribe drugs not listed in the formulary and to send patients to private chemists to purchase them. In at least one instance, a drug representative urged a doctor to ignore Ministry of Health instructions for tuberculosis treatment and always prescribe the third line treatment, which the Ministry warns is "extremely expensive".

Perhaps the biggest difficulty is drug supply. Ruas and Marzagao admit that even essential drugs are not always available, especially in rural areas. Transport is a particular problem. Although the Ministry of Health now has its own lorries, there is still no road linking the north and south of Mozambique! Perhaps most serious has been that there was no way to predict demand for drugs, which has increased sharply, as more people use the new health service, so there has been significant underordering. Rising incomes since independence have also increased the demand for private drugs.

— from *New Scientist*, Sept. 1978.

be eliminated, but rather controlled, including the income of doctors. The translation of this policy into action remains unclear.

In summary, Tanzania has committed its health resources to providing the maximal benefit for the masses. The implementation of this policy has been rapid and impressive, although it is too soon to determine its ultimate effectiveness. As with any progressive policy, internal and external contradictions have occurred and are likely to continue.□

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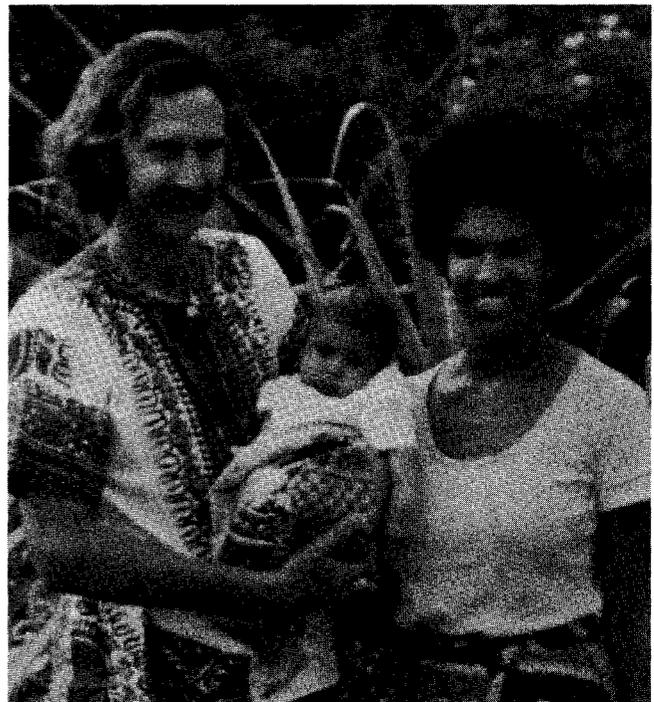
The authors lived in Tanzania from 1974 to 1977. Walter taught community medicine at the Faculty of Medicine in Dar es Salaam and Gail worked in several positions as a nurse. They now live in Cambridge, Mass.

THE FIRST SftP INTERNATIONAL MEETING

The proposed International Meeting of SftP (see the April-May '78 issue of the *Internal Discussion Bulletin*) has been greeted enthusiastically by many members. However, many have suggested it be held in the spring rather than winter. Therefore it has been scheduled for March — in Ann Arbor, Michigan.

Ideas for the agenda and responses to them will be published in the next few issues of the *IDB*. Send them to the Berkeley chapter (Berkeley SftP, PO Box 4161, Berkeley, CA 94704). Think about it, talk about it, and then share your proposals with the rest of us via the IDB.

Yes, we mean YOU!

MIDWEST REGIONAL MEETING

The next Midwest Regional Meeting of Science for the People will be held on November 10th, 11th and 12th in East Lansing, Michigan. The Agenda is being put together by the Ann Arbor chapter; please send your suggestions for subjects to be considered to them. Persons from newly formed chapters or from places without chapters are especially invited. Today the Corn Belt, tomorrow . . . .

KAREN SILKWOOD WEEK

Nov. 13, 1974—Karen Silkwood, a worker in a plutonium plant, died in a suspicious auto crash while on route to explain to a reporter some dangerous safety violations at her plant. The on-going investigation reveals facts of concern to anti-nuclear advocates, environmentalists, feminists, and the labor movement:

—Shortly after Karen was elected to the Steering Committee of her union, she was contaminated with plutonium at the plant on three consecutive days;

—Her death was declared an accident by the Oklahoma authorities but union ivnestigators report evidence her car was hit by another car;

—Documents which were with her in her car, pertaining to the alleged safety violations, disappeared from the car after the accident.

Supporters of Silkwood designate Nov. 13, as a day of remembrance; there will be a vigil that night. On the following Saturday, Nov. 18, a mass rally with speakers will occur. There will be teach-ins from now until Nov. 19. For more information or to help organize a teach-in, call your local mobilization for Survival office (in the Boston area: 617-354-9008), or contact Lynda Taylor in Boston: 617-846-4306 or 617-846-1111.

ORGANIZING FOR COMMUNITY HEALTH IN CHICAGO

by John L. McKnight

The following is an abridged and revised transcript of a recent seminar on community health and development given by John L. McKnight. It is reprinted from Development Dialogue, a journal of international development published by the Dag Hammarskjold Foundation, Ovre Slottsgatan 2, 752 20 Uppsala, Sweden (1978:1).

Is it possible that out of the contradictions of medicine one can develop the possibilities of politics? The example I want to describe is *not* going to create a new social order. It is, however, the beginning of an effort to free people from medical clienthood, so that they can perceive the possibility of being citizens engaged in political action.

The example involves a community of about 60,000 people on the West side of Chicago. The people are poor and black, and the majority are dependent on welfare payments. They have a community organization which is voluntary, not a part of the government. The community organization encompasses an area in which there are two hospitals.

The neighbourhood was originally all white. During the 1960s it went through a racial transition. Over a period of a few years, it became largely populated with black people.

The two hospitals continued (analogous to colonial situations) to serve the white people who had lived in the neighbourhood before transition. The black people, therefore, struggled to gain access to the hospitals' services.

This became a political struggle and the community organization finally 'captured' the two hospitals. The boards of directors of the hospitals then accepted people from the neighbourhood, employed black people on their staffs and treated members of the neighbourhood rather than the previous white clients.

After several years, the community organization felt that it was time to stand back and look at the health status of their community. As a result of their analysis, they found that, although they had 'captured' the hospitals, there was no significant evidence that the health of the people had changed since they had gained control of the medical services.

The organization then contacted the Center for Urban Affairs, where I work. They asked us to assist in finding out why, if the people controlled the two hospitals, their health was not any better.

The Causes of Hospitalization

It was agreed that we would do a study of the hospitals' medical records to see why people were receiving medical care. We also took a sample of the emergency room medical records to determine the frequency of the various problems that brought the people into the hospitals.

by Margaret Burroughs, distinguished Chicago Afro-American artist and writer.

We found that the seven most common reasons for hospitalization, in order of frequency, were:

1. Automobile accidents.
2. Interpersonal attacks.
3. Accidents (non-auto).
4. Bronchial ailments.
5. Alcoholism.
6. Drug-related problems (medically administered and non-medically administered).
7. Dog bites.

The people from the organization were startled by these findings. The language of medicine is focused upon disease — yet the problems we identified have very little to do with disease. The medicalization of health had led them to believe that 'disease' was the problem which hospitals were addressing, but they discovered instead that the hospitals were dealing with many problems which were not 'diseases'. It was an important step in conscientization to recognize that modern medical systems are usually dealing with maladies — social problems — rather than disease. Maladies and social problems are the domain of citizens and their community organizations.

Community Action

Having seen the list of maladies and problems, the people from the organization considered what they ought to do, or could do, about them. I want to describe the first three things that they decided to do because each makes a different point.

First of all, they decided to tackle a problem which they felt they could solve right away. So they chose dog bites, which cause about four per cent of the emergency room visits.

How could this problem best be approached? The city government has employees who are paid to be 'dog-catchers', but the organization did not choose to contact the city. Instead, they said: 'Let us see what we can do ourselves.' They decided to take a small part of their money and use it for 'dog bounties'! Through their block clubs they let it be known that for a period of one month, in an area of about a square mile, they would pay a bounty of five dollars for every stray dog (not house dog) that was brought in to the organization or had its location identified so that they could go and capture it.

There were packs of wild dogs in the neighbourhood that had frightened many people. The children of the neighbourhood, on the other hand, thought that catching dogs was a wonderful idea — so they helped to identify them. In one month, 160 of these dogs were captured and cases of dog bites in the hospitals decreased.

Two things happened as a result of this success. The people began to learn that their action, rather than the hospital, determines their health. They were also building their organization by involving the children as community activists.

The second course of action was to deal with something more difficult — automobile accidents. 'How can we do anything if we don't understand where these accidents are taking place?', the people said. They asked us to try to get information which would help to deal with the accident problem, but we found it extremely difficult to find information regarding 'when', 'where' and 'how' an accident took place.

We considered going back to the hospital and looking at the medical records to determine the nature of the accident that brought each injured person to the hospital. If medicine were a system that was related to the possibilities of community action, it should have been possible. It was not. The medical record did not say, 'This person has a malady because she was hit by an automobile at six o'clock in the evening on January 3rd at the corner of Madison and Kedzie.' Sometimes the record did not even say that the cause was an automobile accident. Instead, the record simply tells you that the person has a 'broken tibia'. It is a record system

that obscures the community nature of the problem, by focusing on the therapeutic to the exclusion of primary cause.

We began, therefore, a search of the data systems of macroplanners. Finally we found one macro-planning group that had data regarding the nature of auto accidents in the city. It was data on a complex, computerized system, to be used in macro-planning to facilitate automobile traffic! We persuaded the planners to do a 'print-out' that could be used by the neighbourhood people for their own action purposes. This had never occurred to them as a use for 'their' information.

We took the numbers and translated them on to a neighbourhood map showing where accidents took place. Where people were injured, we put a blue X. Where people were killed, we put a red X.

We did this for all accidents for a period of three months. There are 60,000 residents living in the neighbourhood. In that area, in three months, there were more than 1,000 accidents. From the map the people could see, for example, that within three months six people had been injured, and one person killed, in an area 60 feet wide. They immediately identified this place as the entrance to a parking lot for a department store.

The experience with the map had two consequences. First, the opportunity was offered to invent several different ways to deal with a health problem that the community could understand. The community organization could negotiate with the department store owner and force a change in the parking lot entrance.

The second consequence was that it became very clear that there were accident problems that the community organization could not handle directly. For example, one of the main reasons for many of the accidents was the fact that higher authorities had decided to make several of the streets through the neighbourhood major throughways for automobiles going from the heart of the city out to the affluent suburbs. Those who made this trip were a primary cause of injury to the local people. Dealing with this problem is not within the control of people at the neighbourhood level — but they understand the necessity of getting other community organizations involved in a similar process, so that together they can assemble enough power to force the authorities to change the suburbanites' policies so that people in the neighbourhoods will benefit.

The third community action activity developed when the people focused on 'bronchial problems'. They learned that good nutrition was a factor in these problems, and concluded that they did not have enough fresh fruit and vegetables for good nutrition. In the city, particularly in the winter, these foods were too expensive. So could they grow fresh fruit and vegetables themselves? They looked around, but it seemed difficult in the heart of the city. Then several people pointed out that most of their houses are two storey apartments with flat roofs: 'Supposing we could build a greenhouse on the roof, couldn't we grow our own fruit and vegetables?' So they built a greenhouse on one of the roofs as an experiment. Then, a fascinating thing began to happen.

Originally, the greenhouse was built to deal with a *health* problem — adequate nutrition. The greenhouse was a tool, appropriate to the environment, that people could make and use to improve health. Quickly, however, people began to see that the greenhouse was also an *economic development* tool. It increased their income because they now produced a commodity to use and also to sell.

Then, another use for the greenhouse appeared. In the United States, energy costs are extremely high and are a great burden for poor people. One of the main places where people lose (waste) energy is from the rooftops of their houses — so the greenhouse on top of the roof converted the energy loss into an asset. The energy that did escape from the house went into the greenhouse where heat was needed. The greenhouse, therefore, was an *energy* conservation tool.

Another use for the greenhouse developed by chance. The community organization owned a retirement home for elderly people, and one day one of the elderly people discovered the greenhouse. She went to work there, and told the other old people and they started coming to the greenhouse every day to help care for the plants. The administrator of the old people's home noticed that the attitude of the older people changed. They were excited. They had found a function. The greenhouse became a tool to *empower older people* — to allow discarded people to be productive.

Conclusions

Let me draw several conclusions from the health work of the community organization.

First, out of all this activity, it is most important that the health action process has strengthened a community organization. Health is a political issue. To convert a medical problem into a political issue is central to health improvement. Therefore, as our action has developed the organization's vitality and power, we have begun the critical health development. Health action must lead away from dependence on professional tools and techniques, towards community building and citizen action. Effective health action must convert a professional-technical problem into a political, communal issue.

Second, effective health action identifies what you can do at the local level with local resources. It must also identify those external authorities and structures that

control the limits of the community to act in the interest of its health.

Third, health action develops tools for the people's use, under their own control. To develop these tools may require us to *diminish* the resources consumed by the medical system. As the community organization's health activity becomes more effective, the swollen balloon of medicine should shrink. For example, after the dogs were captured, the hospital lost clients. Nonetheless, we cannot expect that this action will stop the medical balloon from growing. The medical system will make new claims for resources and power, but our action *will* intensify the contradictions of medicalized definitions of health. We can now see people saying: 'Look, we may have saved 185 dollars in hospital care for many of the 160 dogs that will not now bite people. That's a lot of money! But it stays with that hospital. We want our 185 dollars! We want to begin to trade in an economy in which you don't exchange our action for more medical service. We need income, not therapy. If we are to act in our health interest, we will need the resources medicine claims for its therapeutic purposes in order to diminish our therapeutic need.'

The three principles of community health action suggest that 'Another Development in Health' is basically about moving *away* from being 'medical consumers' with the central goal being full access to medical care. Rather, the experience I have described suggests that the sickness which we face is the captivity of tools, resources, power and consciousness by a medical system that creates consumers.

Health is a political question. It requires citizens and communities. The health action process can enable 'another health development' by translating medically
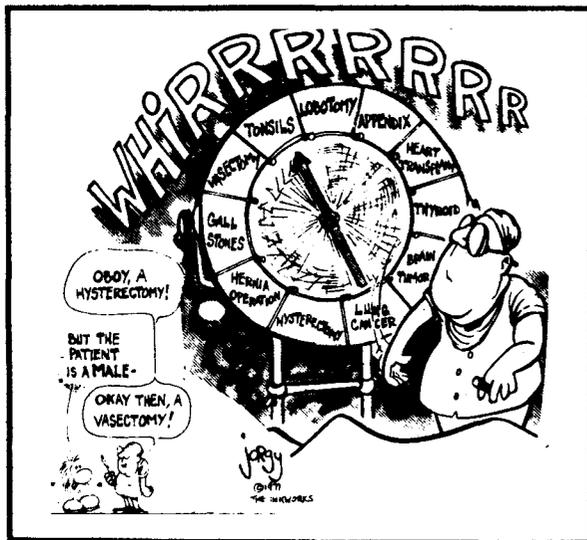
defined problems and resources into politically actionable community problems.

* * * * *

From the discussion following the presentation:

Some doctors talk of the wider ramifications of automobile accidents, the relationship of alcoholism and drugs to those accidents, and the lack of decent housing. To say those are 'social diseases' is to place within the realm of the medical system issues which are *political* questions. That's why I think that 'social disease' is a tragic, final effort by the medical imperial system to preserve its colonial powers over citizen actions.

The process that I described is a limited activity. Certainly catching the dogs is not a major undertaking. But it is the first step. As each step goes on, the strength of the organization, its capacity to deal with problems and to identify the controlling sectors of the society, becomes more and more obvious.

The best hope is that people will learn exactly what the primary causes are. But no medical system will ever teach that. It is a political question, requiring community organization, struggle and the reallocation of power and authority. When we call that an issue of 'social disease', affirming the hegemony of medical systems, we just undermine everything we are trying to enable in 'another health development'.

* * * * *

In our country there are not, in my view, any more medical services that are really needed. In fact we are at the point of almost apparent absurdity in the 'manufacture of need', in order to justify more services to keep the unemployment down!

What we need is 'good work' rather than therapeutic 'good works'. Let me explain. The neighbourhood I described has dilapidated housing, houses burning every other night, abandoned buildings everywhere, terrible environmental conditions. Adjacent to this neighbourhood is Chicago's largest Medical Center (where many Third World doctors are being trained, incidentally). The neighbourhood has steadily declined because of racism and the drain of resources. At the same time there seems to be no end to the Medical Center's growth. As I walk the 30 blocks from the Medical Center with its growing towers into the decaying neighbourhood, I know that there is good work to be done — and it's not the good works going on in that Medical Center.

We do not need more of the Medical Center's therapy. We need to steal its money, resources and power in order that the community organization will have the capacity to improve the health of the people. □

A MARXIST VIEW OF MEDICAL CARE

by Howard Waitzkin

Howard Waitzkin is a health worker at La Clinica de la Raza, a community health center in Oakland, California.

This article surveys the Marxist literature in medical care. The Marxist viewpoint questions whether major improvements in the health system can occur without fundamental changes in the broad social order. One thrust of the field — an assumption also accepted by many non-Marxists — is that the problems of the health system reflect the problems of our larger society and cannot be separated from those problems.

Marxist analyses of health care have burgeoned in the United States during the past decade. However, it is not a new field. Its early history and the reasons for its slow growth until recently deserve attention.

Historical Development of the Field

The first major Marxist study of health care was Engels' *The Condition of the Working Class in England,* originally published in 1845 — three years before Engels co-authored with Marx *The Communist Manifesto.* This book described the dangerous working and housing conditions that created ill health. In particular, Engels traced such diseases as tuberculosis, typhoid, and typhus to malnutrition, inadequate housing, contaminated water supplies, and overcrowding. Engels' analysis of health care was part of a broader study of working-class conditions under capitalist industrialization. But his treatment of health problems was to have a profound effect on the emergence of social medicine in Western Europe and, in particular, on the work of Rudolph Virchow.

Virchow's pioneering studies in infectious disease, epidemiology, and "social medicine" (a term Virchow popularized in Western Europe) appeared soon after the publication of Engels' book. Virchow himself acknowledged Engels' influence on this thought. In 1847, at the request of the Prussian government, Virchow investigated a severe typhus epidemic in a rural area of the country. Based on this study, he recommended a series of profound economic, political, and social changes that included increased employment, better wages, local autonomy in government, agricultural cooperatives, and a more progressive taxation structure.

Virchow advocated no strictly medical solutions, like' more clinics or hospitals. Instead, he saw the origins of ill health in societal problems. The most reasonable approach to the problem of epidemics, then, was to change the conditions that permtited them to occur.

During this period Virchow became committed to combining his medical work with political activities. In 1848 he joined the first major working-class revolt in Berlin. During the same year he strongly supported the short-lived revolutionary efforts of the Paris Commune(1). In his scientific investigations and in his political practice, Virchow expressed two overriding themes. First, that there are many interacting causes of disease. Among the most important factors in causation are the material conditions of people's everyday lives. Secondly, an effective health-care system cannot limit itself to treating the illnesses of individual patients. Instead, to be successful, improvements in the health-care system must coincide with fundamental economic, political, and social changes. The latter changes often impinge upon the privileges of wealth and power enjoyed by the dominant classes of society and encounter resistance. Therefore, in Virchow's view, the responsibilities of the medical scientist frequently extend to direct political action.

After the revolutionary struggles of the late 1840s suffered defeat, Western European governments heightened their conservative social policies. Marxist analysis of health care entered a long period of eclipse, and Virchow and his colleagues turned to relatively uncontroversial research in laboratories and to private practice.

During the late nineteenth century, with the work of Ehrlich, Koch, Pasteur, and other prominent bacteriologists, germ theory gained ascendancy and created a profound change in medicine's diagnostic and therapeutic assumptions. A single-factor model of disease emerged. Medical scientists searched for organisms causing infections and single lesions in non-infectious disorders. The discoveries of this period undeniably improved medical practice. Still, as numerous investigators have shown, the historical importance of these discoveries has been overrated. For example, the major declines in mortality and morbidity from most infectious diseases preceded rather than followed the isolation of specific "germs" and the use of anti-microbial therapy. In Western Europe and the United States, improved outcomes in infections occurred after the introduction of better sanitation, regular sources of nutrition, and other broad environmental changes. In most cases, improvements in disease patterns antedated the advances of modern bacteriology(2-4).

Why did the unifactorial perspective of germ theory achieve such prominence? And why have the investigational techniques based on this perspective retained a nearly mythic character in medical science and practice to the present day? A serious historical re-examination of early twentieth century medical science, that attempts to answer these questions, has begun only in the last few years. Some preliminary explanations have emerged; they focus on events that led to and followed publication of the Flexner Report on medical education in 1910(5).

The Flexner Report has held high esteem as the document that helped change modern medicine from quackery to responsible practice. One underlying assumption of the Report was that laboratory-based scientific medicine, oriented especially to the concepts and methods of European bacteriology, produced a higher quality and more effective medical practice. Although the comparative effectiveness of various medical traditions (including homeopathy, traditional folk healing, chiropractic, etc.) had never been subjected to systematic test, the Report argued that medical schools not oriented to scientific medicine fostered mistreatment of the public. The Report called for the closure or restructuring of schools that were not equipped to teach laboratory-based medicine. The Report's repercussions were swift and dramatic. Scientific, laboratory-based medicine became the norm for medical education, practice, research, and analysis.

Recent historical studies cast doubt on assumptions in the Flexner Report that have comprised the widely accepted dogma of the last century. They also document the un-critical support that the Report's recommendations received from parts of the medical profession and the large private philanthropies(6-8). At least partly because of these events, the Marxist orientation in medical care remained in eclipse.

Although some of Virchow's works gained recognition as classics, the multifactorial and politically oriented model that guided his efforts has remained largely buried. Without doubt, Marxist perspectives had important impacts on health care outside Western Europe and the United States. For example, Lenin applied these perspectives to the early construction of the Soviet health system. Salvador Allende's treatise on the political economy of health care, written while Allende was working as a public health physician, exerted a major influence on health programs in Latin America. The Canadian surgeon, Norman Bethune, contributed analyses of tuberculosis and other diseases, as well as direct political involvement, that affected the course of post-revolutionary Chinese medicine(9). Che Guevara's analysis of the relations among politics, economics, and health care — emerging partly from his experience as a physician — helped shape the Cuban medical system(10,11).

Perhaps reflecting the political ferment of the late 1960s and widespread dissatisfaction with various aspects of modern health systems, serious Marxist

scholarship of health care has grown rapidly(38). The following sections of this review cover some of the current areas of research and analysis.

Class Structure

Marx's definitions of social class emphasized the social relations of economic production. He noted that one group of people, the capitalist class or bourgeoisie, own and/or control the means of production — the machines, factories, land, and raw materials necessary to make products for the market. The working class or proletariat, who do not own or control the means of production, must sell their labor for a wage. But the value of the product that workers produce is always greater than their wage. Workers must give up their product to the capitalist; by losing control of their own productive process, workers become subjectively "alienated" from their labor. The need to maintain profits motivates the capitalist to keep wages low, to change the work process (by automation and new technologies, close supervision, lengthened work day or overtime, speed-ups and dangerous working conditions), and to resist workers' organized attempts to gain higher wages or more control in the workplace.

While acknowledging the historical changes that have occurred since Marx's time, recent Marxist studies have reaffirmed the presence of highly stratified class structures in advanced capitalist societies and Third World nations(13). Another topic of great interest is the persistence or reappearance of class structure, usually based on expertise and professionalism, in countries where socialist revolutions have taken place(14); a later section of the review focuses on this problem. These theoretical and empirical analyses show that relations of economic production remain a primary basis of class structure and a reasonable focus of strategies for change.

Control over health institutions. Navarro has documented the pervasive control that members of the corporate and upper-middle classes exert within the policy-making bodies of American health institutions(15). These classes predominate on the governing boards of private foundations in the health system, private and state medical teaching institutions, and local voluntary hospitals. Only on the boards of state teaching institutions and voluntary hospitals do members of the lower middle class or working class gain any appreciable representation; even there, the participation from these classes falls far below their proportion in the general population. Navarro has argued, based partly on these observations, that control over health institutions reflects the same patterns of class dominance that have arisen in other areas of American economic and political life.

Stratification within health institutions. As members of the upper middle class, physicians occupy the highest stratum among workers in health institutions. Comprising 7 percent of the health labor force, physicians receive a median net income (approximately $53,900 in 1975) that places them in the upper 5 percent of the income distribution of the United States. Under physicians and professional administrators are members of the lower middle class: nurses, physical and occupational therapists and technicians. They make up 29 percent of the health labor force, are mostly women, and earn about $8,500. At the bottom of institutional hierarchies are clerical workers, aides, orderlies, kitchen and janitorial personnel, who are the working class of the health system. They have an income of about $5,700 per year, represent 54 percent of the health labor force, and are 84 percent female and 30 percent black(15).

Recent studies have analyzed the forces of professionalism, elitism, and specialization that divide health workers from each other and prevent them from realizing common interests. These patterns affect physicians(16), nurses, and technical and service workers who comprise the fastest growing segment of the health labor force(17). Bureaucratization, unionization, state intervention, and the potential "proletarianization" of professional health workers may alter future patterns of stratification.

Occupational mobility. Class mobility into professional positions is quite limited. Investigations of physicians' class backgrounds in both Britain and the United States have shown a consistently small representation of the lower middle and working classes among medical students and practicing doctors(18). As Ziem has found, despite some recent improvements for blacks and women, recruitment of working-class medical students as a whole has been very limited since shortly after publication of the Flexner Report. In 1920, 12 percent of medical students came from working-class families, and this percentage has stayed almost exactly the same until the present time.

Emergence of Monopoly Capital in the Health Sector

During the past century, economic capital has become more concentrated in a smaller number of companies — the monopolies. Monopoly capital has become a prominent feature of most capitalist health systems and is manifest in several ways.

Medical centers. Since about 1910, a continuing growth of medical centers has occurred, usually in affiliation with universities. Capital is highly concentrated in these medical centers, which are heavily oriented to advanced technology. Practitioners have received training where technology is available and specialization is

highly valued. Partly as a result, health workers are often reluctant to practice in areas without easy access to medical centers. The nearly unrestricted growth of medical centers, coupled with their key role in medical education and the "technologic imperative" they encourage, has contributed to the maldistribution of health workers and facilities throughout the United States and within regions(12,16).

Finance capital. Monopoly capital also has been apparent in the position of banks, trusts, and insurance companies — the largest profit-making corporations under capitalism. For example, in 1973, the flow of health-insurance dollars through private insurance companies was $29 billion, about one-half of the total insurance sold. Among commercial insurance companies, capital is highly concentrated; about 60 percent of the health-insurance industry is controlled by the ten largest insurers. Metropolitan Life and Prudential each control over $30 billion in assets, more than General Motors, Standard Oil of New Jersey, or International Telephone and Telegraph(15).

Finance capital figures prominently in current health reform proposals. Most plans for national health insurance would permit a continuing role for the insurance industry. Moreover, corporate investment in health maintenance organizations is increasing, under the assumption that national health insurance, when enacted, will assure the profitability of these ventures(19).

The "medical-industrial complex." The "military-industrial complex" has provided a model of industrial penetration in the health system, popularized by the term, "medical-industrial complex." Investigations by the Health Policy Advisory Center(20) and others have emphasized that the exploitation of illness for private profit is a primary feature of the health systems in advanced capitalist societies(16). Recent reports have criticized the pharmaceutical amd medical equipment industries for advertising and marketing practices(20,21), price and patent collusion(22), marketing of largely untested drugs in the Third World, and promotion of expensive diagnostic and therapeutic innovations without controlled trials demonstrating their effectiveness.

In this context, "cost-effectiveness" analysis has yielded useful appraisals of several medical practices and clinical decision making, based in part on analysis of cost relative to effectiveness(23). While recognizing its contributions, Marxist researchers have criticized the cost-effectiveness approach for asking some questions at the wrong level of analysis. This approach usually does not help clarify the over-all dynamics of the health system that encourage the adoption of costly and ineffective technologic innovations. The practices evaluated by cost-effectiveness research generally emerge with the growth of monopoly capital in the health system. Costly innovations often are linked to the expansion of medical

centers, the penetration of finance capital in the health system, and the promotion of new drugs and instrumentation by medical industries. Cost-effectiveness research and clinical decision analysis remain incomplete unless they consider broader political and economic trends that propel apparent irrationalities in the health system(90).

The State and State Intervention

Marx and Engels emphasized the state's crucial role in protecting the capitalist economic system and the interests of the capitalist class. The state comprises the interconnected public institutions that act to preserve the capitalist economic system and the interests of the capitalist class. This definition includes the executive, legislative, and judicial branches of government, the military, and the criminal justice system, all of which hold varying degrees of coercive power. It also encompasses relatively non-coercive institutions within the educational, public welfare, and health-care systems. Through such non-coercive institutions, the state offers services or conveys ideologic messages that both stabilize and legitimate the capitalist system. Especially in periods of economic crisis, the state can use these same institutions to provide public subsidization of private enterprise.

The private-public contradiction. Within the health system, the "public sector," as part of the state, operates through public expenditures and employs health workers in public institutions. The "private sector" is based in private practice and in companies that manufacture medical products or control medical finance capital. Nations vary greatly in the private-public duality. In the United States, a dominant private sector coexists with an increasingly large public sector. The public sector is even larger in Great Britain and Scandinavia. In Cuba and China, the private sector has been essentially eliminated(16).

A general theme of Marxist analysis is that the private sector drains public resources and health workers' time, in behalf of private profit and to the detriment of patients using the public sector. This framework has helped explain some of the problems that have arisen in such countries as Great Britain(18) and Chile, where private sectors persisted after the enactment of national health services. In these countries, practitioners have faced financial incentives to increase the scope of private practice, which they often have conducted within public hospitals or clinics. In the United States, the expansion of public payment programs such as Medicare and Medicaid has led to increased public subsidization of private practice and private hospitals, as well as abuses of these programs by individual practitioners(16).

Similar problems have undermined other public
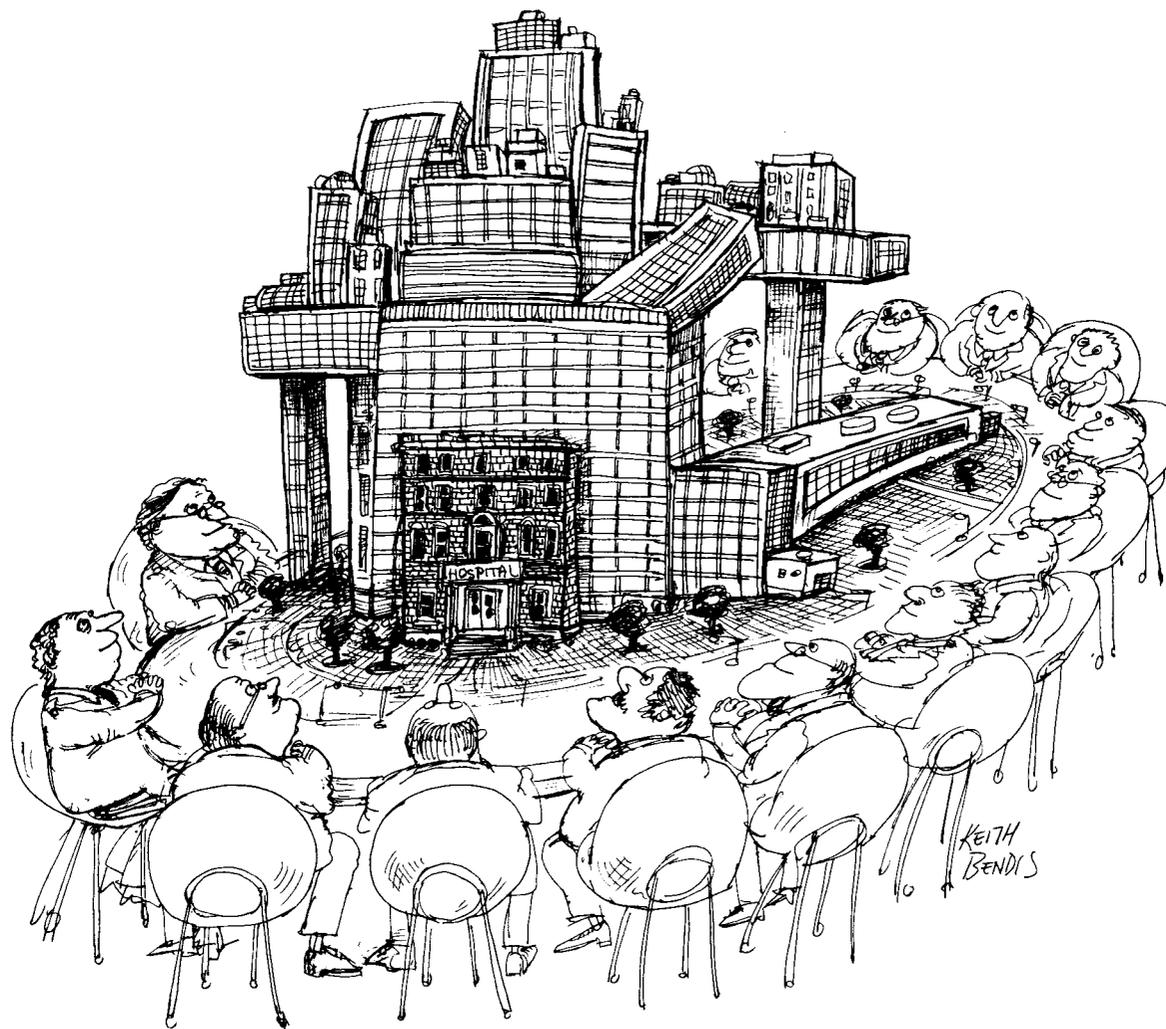
health programs. These programs frequently have obtained finances through regressive taxation, placing low-income taxpayers at a relative disadvantage. Likewise, the deficiencies of the Blue Cross-Blue Shield insurance plans have derived largely from the failure of public regulatory agencies to control payments to practitioners and hospitals in the private sector. When enacted, national health insurance also would use public funds to reinforce and strengthen the private sector, by assuring payment for hospitals and individual physicians and possibly by permitting a continued role for commercial insurance companies(16).

Throughout the United States the problems of the private-public contradiction are becoming more acute. In most large cities, public hospitals are facing cutbacks, closure, or conversion to private ownership and control. This trend heightens low-income patients' difficulties in finding adequate health care. It also reinforces private hospitals' tendency to "dump" low-income patients to public institutions(27).

General functions of the state within the health system. The state's functions in the health system have increased in scope and complexity. In the first place,

through the health system, the state acts to legitimate the capitalist economic system based in private enterprise(16,28). The history of public health and welfare programs shows that state expenditures usually increase during periods of social protest and decrease as unrest becomes less widespread(29). Recently a Congressional committee summarized public opinion surveys that uncovered a profound level of dissatisfaction with government and particularly the role of business interests in government policies: ". . . citizens who thought something was 'deeply wrong' with their country had become a national majority . . . . And, for the first time in the ten years of opinion sampling by the Harris Survey, the growing trend of public opinion toward disenchantment with government swept more than half of all Americans with it." Under such circumstances, the state's predictable response is to expand health and other welfare programs. These incremental reforms, at least in part, reduce the legitimacy crisis of the capitalist system by restoring confidence that the system can meet the people's basic needs. The cycle of political attention devoted to national health insurance in the United States appear to parallel cycles of popular discon-

tent(16). Recent cutbacks in public health services to low-income patients follow the decline of social protest by low-income groups since the 1960s.

The second major function of the state in the health system is to protect and reinforce the private sector more directly. As previously noted, most plans for national health insurance would permit a prominent role and continued profits for the private insurance industry, particularly in the administration of payments, record keeping, and data collection(16). Corporate participation in new health initiatives sponsored by the state — including health maintenance organizations, preventive screening programs, computerized components of professional standards review organizations, algorithm and protocol development for para-professional training, and audiovisual aids for patient education programs — is providing major sources of expanded profit(19).

A third (and subtler) function of the state is the reinforcement of dominant frameworks in scientific and clinical medicine that are consistent with the capitalist economic system, and the suppression of alternative frameworks that might threaten the system. The United States government has provided generous funding for research on the physiology and treatment of specific diseases. As critics even within government have recognized, the disease-centered approach has reduced the level of analysis to the individual organism and, often inappropriately, has stimulated the search for single rather than multiple causes. More recently, analyses emphasizing the importance of individual "life style" as a cause of disease(3,30) have received prominent attention by state agencies in the United States and Canada. Clearly, individual differences in personal habits do affect health in all societies. On the other hand, the life-style argument, perhaps even more than the earlier emphasis on specific etiology, obscures important sources of illness and disability in the capitalist work process and industrial environment; it also puts the burden of good health squarely on the individual, rather than seeking collective solutions to health problems(15, 31).

The issues that the state has downplayed in its research and development programs are worth noting. For example, based on available data, it is estimated that in Western industrialized societies environmental factors are involved in approximately 80 percent of all cancers. In its session on "health and work in America," the American Public Health Association in 1975 produced an exhaustive documentation of common occupational carcinogens(32). A task force for the Department of Health, Education and Welfare on "Work in America," published by a non-government press in 1973, reported: "In an impressive 15-year study of aging, the strongest predictor of longevity was work satisfaction. The second best predictor was overall 'happiness'. . . Other factors are undoubtedly important — diet, exercise, medical care, and genetic inheritance. But research findings suggest that these factors may account for only about 25 percent of the risk factors in heart disease, the major cause of death . . ."(33). Such findings are threatening to the current organization of capitalist production. They have received little attention or support from state agencies. A framework for clinical investigation that links disease directly to the structure of capitalism is likely to face indifference or active discouragement from the state.

Medical Ideology

Ideology is an interlocking set of ideas and doctrines that form the distinctive perspective of a social group. Along with other institutions like the educational system, family, mass media, and organized religion, medicine promulgates an ideology that helps maintain and reproduce class structure and patterns of domination. Medicine's ideologic features in no way diminish

the efforts of individuals who use currently accepted methods in their clinical work and research. Nevertheless, medical ideology, when analyzed as part of the broad social superstructure, has major social ramifications beyond medicine itself. Recent studies have identified several components of modern medical ideology:

1) *Disturbances of biological homeostasis are equivalent to breakdowns of machines.* Modern medical science views the human organism mechanistically. The health professional's advanced training permits the recognition of specific causes and treatments for physical disorders. The mechanistic view of the human body deflects attention from environmental causes of disease, including work processes or social stress. It also reinforces a general ideology that favors industrial technology under specialized control(15,34).

2) *Disease is a problem of the individual human being.* The unifactorial model of disease has always focused on the individual rather than the illness-generating conditions of society. More recently,

attempts have been made to blame disease on an individual's "life style" (smoking, overeating, etc.). In both cases, the responsibility for disease and cure rests at the individual rather than the collective level. In this sense medical science offers no basic critical appraisal of class structure and relations of production, even in their implications for health and illness(15).

3) *Science permits the rational control of human beings.* The natural sciences have led to a greater control over nature. Similarly, it is often assumed that modern medicine, by correcting defects of individuals, can enhance their controllability. The quest for a reliable work force has been one motivation for the support of modern medicine by capitalist economic interests (8). Physicians' certification of illness historically has expanded or contracted to meet industry's need for labor(35). Thus, medicine is seen as contributing to the rational governance of society, and managerial principles increasingly are applied to the organization of the health system(25).

4) *Many spheres of life are appropriate for medical management.* This ideologic assumption has led to an expansion of medicine's social control function. Many behaviors that do not adhere to society's norms have become appropriate for management by health professionals. The "medicalization of deviance" and health workers' role as agents of social control have received critical attention (3,16,36,37). The medical management of behavioral difficulties, such as hyperactivity, and aggression, often coincides with attempts to find specific biological lesions associated with these behaviors (38,39). Historically, medicine's social control function has expanded in periods of intense social protest or rapid social change.

5) *Medical science is both esoteric and excellent.* According to this ideologic principle, medical science involves a body of advanced knowledge and standards of excellence in both research and practice. Because scientific knowledge is esoteric, a group of professionals tend to hold elite positions. Lacking this knowledge, ordinary people are dependent on professionals for interpretation of medical data. The health system therefore reproduces patterns of domination by "expert" decision makers in the workplace, government, and many other areas of social life. The ideology of excellence helps justify these patterns, although the quality of much medical research and practice is far from excellent; this contradiction recently has been characterized as "the excellence deception" in medicine(40). Ironically, a similar ideology of excellence has justified the emergence of new class hierarchies based on expertise in some countries, like the Soviet Union, that have undergone socialist revolutions. Other countries, such as the People's Republic of China, have tried to overcome these ideologic assumptions and to develop a less esoteric "people's medicine."

Studies of medical ideology have focused on public statements by leaders of the profession (in professional journals or the mass media), as well as state and corporate officials whose organizations regulate or sponsor medical activities. However, health professionals also express ideologic messages in their face-to-face interaction with patients(36). The transmission of ideologic messages within doctor-patient interaction currently is the subject of empirical research(41).

Comparative International Health Systems

Health care and imperialism. Imperialism may be defined as capital's expansion beyond national boundaries, as well as the social, political, and economic effects of this expansion. One basic feature of imperialism is the extraction of raw materials and human resources which move from Third World nations to economically dominant countries. Navarro has analyzed how the "underdevelopment of health" in the Third World follows inevitably from this depletion of natural and human resources. The extraction of wealth limits underdeveloped countries' ability to construct effective health systems. Many Third World countries face a net loss of health workers who migrate to economically dominant nations after expensive training at home(15).

Through imperialism, corporations also seek a cheap labor force. Workers' efficiency was one important goal of public health programs sponsored abroad, especially in Latin America and Asia, by philanthropies closely tied to expanding industries in the United States(8). Moreover, population control programs initiated by the United States and other dominant countries have sought a more reliable participation by women in the labor force(42). At the same time, workers abroad who are employed by multinational corporations also face high risks of occupational disease.

Another thrust of imperialism is the creation of new markets for products manufactured in dominant nations and sold in the Third World. This process is nowhere clearer than in the pharmaceutical and medical equipment industries. The penetration of these multinationals, with its stultifying impact on local medical research and development, has led to the advocacy of nationalized drug and equipment formularies in several Third World countries.

As in the United States, medical professionals in the Third World most often come from higher income families. Even when they do not, they frequently view medicine as a route of upward mobility. As a result, medical professionals tend to ally themselves with the capitalist class — the "national bourgeoisie" — of Third World countries. They also frequently support cooperative links between the local capitalist class and business interests in economically dominant countries. The class position of health professionals has led them to resist

social change that would threaten current class structure, either nationally or internationally. Similar patterns have emerged in some post-revolutionary societies. In the U.S.S.R., professionals' new class position, based on expertise, has caused them to act as a relatively conservative group in periods of social change. Elitist tendencies in the post-revolutionary Cuban profession also have received criticism from Marxist analysts(43).

Frequently imperialism has involved direct military conquest; recently health workers have assumed military or paramilitary roles in Indochina and Northern Africa. Health institutions also have taken part as bases for counterinsurgency and intelligence operations in Latin America and Asia.

Health care and the transition to socialism. The number of nations undergoing socialist revolutions has increased dramatically in recent years, particularly in Asia and Africa but also in parts of Latin America, the Caribbean, and Southern Europe. Socialism is no panacea. Numerous problems have arisen in all countries that have experienced socialist revolutions. The contradictions that have emerged in most postrevolutionary countries are deeply troubling to Marxists; these contradictions have been the subject of intensive analysis and debate.

On the other hand, socialism can produce major modifications in health-system organization, nutrition, sanitation, housing, and other services. These changes can lead, through a sometimes complex chain of events, to remarkable improvements in health. The remarkable improvements in morbidity and mortality that followed socialist revolutions in such countries as Cuba and China now are well known(43,45-47). The transition to socialism in every case has resulted in reorganization of the health system, emphasizing better distribution of health care facilities and personnel. Local political groups in the commune, neighborhood, or workplace have assumed responsibility for health education and preventive medicine programs. Class struggle continues throughout the transition to socialism. During Chile's brief period of socialist government, many professionals resisted democratization of health institutions and supported the capitalist class that previously and subsequently ruled the country(15,44). Countries like China and Cuba eliminated the major source of social class — the private ownership of the means of production. However, as mentioned previously, new class relations began to emerge that were based on differential expertise. Health professionals received larger salaries and maintained higher levels of prestige and authority. One focus of the Chinese Cultural Revolution was the struggle against the new class of experts that had gained power in the health system and elsewhere in the society(31). Other countries, including Cuba, have not confronted these new class relations as explicitly (see article on Health Care in Tanzania elsewhere in this issue).

Contradictions of capitalist reform. While retaining the essential features of their capitalist economic systems, several nations in Europe and North America have instituted major reforms in their health systems. Some reforms have produced beneficial effects that U.S. policy makers view as possible models for this country. However, recent Marxist studies, while acknowledging many improvements, have revealed troublesome contradictions that seem inherent in reforms attempted within capitalist systems.

Great Britain's national health service has attracted great interest. Serious problems have balanced many of the undeniable benefits that the British health service has achieved. Chief among these problems is the professional and corporate dominance that has persisted since the service's inception. Decision-making bodies contain large proportions of professional specialists, bankers, and corporate executives, many of whom have direct or indirect links with pharmaceutical and medical equipment industries(18,24).

The private-public contradiction, discussed earlier, has remained a source of conflict in several countries that have established national health services or universal insurance programs. Use of public facilities for private practice has generated criticism focusing on public subsidization of the private sector. In Britain, for example, this concern (along with more general organizational problems that impeded comprehensive care) was a primary motivation for the recent reorganization of the national health service(24). In Chile, the attempt to reduce the use of public facilities for private practice led to crippling opposition from the organized medical profession. The private-public contradiction will continue to create conflict and to limit progress when countries institute national health services while preserving a strong private sector.

The limits of state intervention also have become clearer from the examples of Quebec and Sweden. Both have tried to establish far-reaching programs of health insurance, while preserving private practice and corporate dealings in pharmaceuticals and medical equipment. Recent studies have demonstrated the inevitable constraints of such reform. Maldistribution of facilities and personnel have persisted, and costs have remained high. The accomplishments of Quebec's and Sweden's reforms cannot pass beyond the state's responsibility for protecting private enterprise(28). This observation leads to skepticism about health reforms in the United States that rely on private market mechanisms and that do not challenge the broader structures within which the health system is situated(16,48).

Historical Materialist Epidemiology

Historical materialist epidemiology relates patterns of death and disease to the political, economic, and social structures of society. The field emphasizes chang-

ing historical patterns of disease and the specific material circumstances under which people live and work. These studies try to transcend the individual level of analysis, to find how historical social forces influence or determine health and disease.

Many different diseases have been examined from this viewpoint. The incidence of mental illness, for example, has been shown to correlate with economic growth or recession (49). The cause of stress and stress-related problems, such as coronary heart disease, anxiety, suicide, hypertension, and cancer, generally has been viewed as a problem at the individual level. Historical materialist epidemiology shifts the emphasis to stressful forms of social organization linked to capitalist production and industrialization (50,51).

The social causes of occupational disease have become more apparent. Diseases such as asbestosis, mesothelioma, and complications of vinyl chloride all point to the contradiction between profitability and improved health in capitalist countries. Sexism also can

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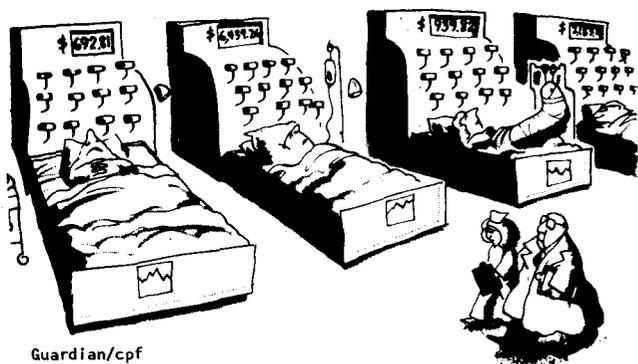
be seen as a factor in the differential production of ill health among women and men. Men, for instance, generally die younger than women, and this may be a result of their greater exposure to occupational hazards in jobs from which women traditionally have been excluded. Historically, a woman's access to health facilities and the way she is treated by doctors have been strongly influenced by her social class. The history of the birth control movement (52), the sexist assumptions of psychiatric diagnosis (see article on the Worcester Ward in this issue) and the misuse of gynecologic surgery all illustrate the social and sexist nature of women's health problems(15).

One unifying theme in this field is modern medicine's limitations(4). Traditional epidemiology has searched for causes of morbidity and mortality that are amenable to medical intervention. While acknowledging the importance of traditional techniques, historical materialist epidemiology has demonstrated causes of disease and death that derive from broad social structures beyond the reach of medicine alone.

Health Praxis

Marxist research conveys another basic message: that research is not enough. "Praxis," as proposed throughout the history of Marxist scholarship, is the disciplined uniting of thought and practice, study and action.

Contradictions of patching. Health workers concerned about progressive social change face difficult dilemmas in their day-to-day work. Clients' problems often have roots in the social system. Examples abound: drug addicts and alcoholics who prefer numbness to the pain of confronting problems like unemployment and inadequate housing; persons with occupational diseases that require treatment but will worsen upon return to illness-generating work conditions; people with stress-related cardiovascular disease; elderly or disabled people who need periodic medical certification to obtain welfare benefits that are barely adequate; prisoners who develop illness because of prison conditions(16,53). Health workers usually feel obliged to respond to the expressed needs of these and many similar clients.

In doing so, however, health workers engage in "patching." On the individual level, patching usually permits clients to keep functioning in a social system that is often the source of the problem. At the societal level, the cumulative effect of these interchanges is the patching of a social system whose patterns of oppression frequently cause disease and personal unhappiness. The medical model that teaches health workers to serve individual patients deflects attention from this difficult and frightening dilemma(16).

The contradictions of patching have no simple resolution. Clearly health workers cannot deny services to clients, even when these services permit clients' continued participation in illness-generating social structures. On the other hand, it is important to draw this connection between social issues and personal troubles. Health praxis should link clinical activities to efforts aimed directly at basic sociopolitical change.

Reformist versus nonreformist reform. When oppressive social conditions exist, reforms to improve them seem reasonable. However, the history of reform in capitalist countries has shown that reforms most often follow social protest, make incremental improvements that do not change overall patterns of oppression, and face cutbacks when protest recedes. Health praxis includes a careful study of reform proposals and the advocacy of reforms that will have a long-term progressive impact.

A distinction developed by Gorz clarifies this problem. "Reformist reforms" provide small material improvements while leaving intact current political and economic structures. These reforms may reduce discon-

tent for periods of time, while helping to preserve the system in its present form. "A reformist reform is one which subordinates objectives to the criteria of rationality and practicability of a given system and policy . . . (it) rejects those objectives and demands — however deep the need for them — which are incompatible with the preservation of the system"(54). "Nonreformist reforms," on the other hand achieve true and lasting changes in the present system's structures of power and finance. Rather than obscuring sources of exploitation by small incremental improvements, nonreformist reforms expose and highlight structural inequities. Such reforms ultimately increase frustration and political tension in a society; they do not seek to reduce these sources of political energy. As Gorz puts it: ". . . although we should not reject intermediary reforms . . ., it is with the strict proviso that they are to be regarded as a means and not an end, as dynamic phases in a progressive struggle, not as stopping places"(54). From this viewpoint health workers can try to discern which current health reform proposals are reformist and which are nonreformist. They also can take active advocacy roles, supporting the latter and opposing the former. Although the distinction is seldom easy, it has received detailed analysis with reference to specific proposals(16,20,48).

Reformist reforms would not change the overall structure of the health system in any basic way. For example, national health insurance chiefly would create changes in financing, rather than in the organization of the health system. This reform may reduce the financial crises of some patients; it would help assure payment for health professionals and hospitals. On the other hand, national health insurance will do very little to control profit for medical industries or to correct problems of maldistributed health facilities and personnel. Its incremental approach and reliance on private market processes would protect the same economic and professional interests that currently dominate the health system(16,20,48).

Other examples of reformist reforms are health maintenance organizations, prepaid group practice, medical foundations, and professional standards review organizations (16,48). With the rare exception of those organized as consumer cooperatives, these innovations preserve professional dominance in health care. There have been few incentives to improve existing patterns of maldistributed services. Moreover, large private corporations have entered this field rapidly, sponsoring profit-making health maintenance organizations and marketing technologic aids for peer review(19).

Until recently, there has been little support for a national health service in the United States. For several years, however, Marxist analysts have worked with members of Congress in drafting preliminary proposals for a national health service. These proposals, if enacted, would be progressive in several ways. They promise to place stringent limitations on private profit in the health sector. Most large health institutions gradually would come under state ownership. Centralized health planning would combine with policy input from local councils to foster responsiveness and to limit professional dominance. Financing by progressive taxation is designed explicitly to benefit low-income patients. Periods of required practice in underserved areas would address the problem of maldistribution. The eventual development of a national drug and medical equipment formulary promises to curtail monopoly capital in the health sector.
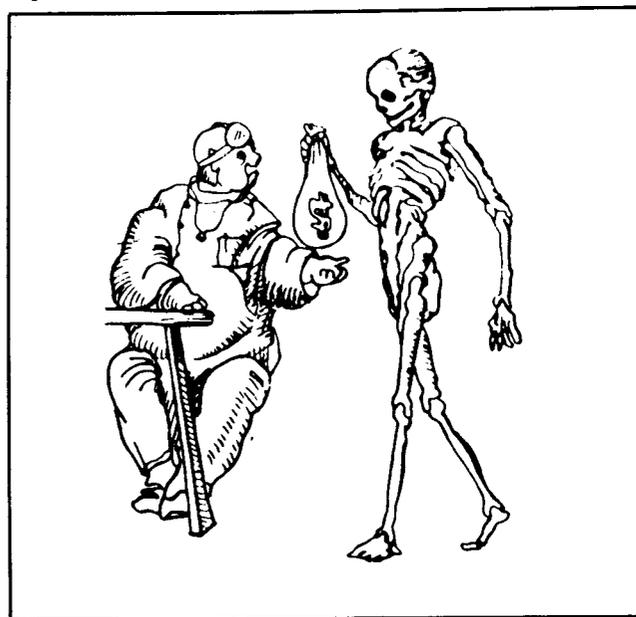
Although these proposals face dim political prospects, support is growing. For instance, the Governing Council of the American Public Health Association has passed two resolutions supporting the concept of a national health service that would be community-based and financed by progressive taxation(55). While advancing a model for a more responsive health care system, this reform also contains contradictions that probably would generate frustration and pressure for change. In particular, these proposals would permit the continuation of private practice and help expose the inequities of the private-public dichotomy.

Health care and political struggle. Fundamental social change, however, comes not from legislation but from direct political action. Currently, coalitions of community residents and health workers are trying to gain control over the governing bodies of health institutions that affect them(26). Unionization activity and minority group organizing in health institutions are exerting pressure to modify previous patterns of stratification(56).

Recognizing the impact of medical ideology has motivated attempts to demystify current ideologic patterns and to develop alternatives. This "counter-hegemonic" work often involves opposition to the social control function of medicine in such areas as drug addiction, genetic screening, contraception and sterilization abuse, psychosurgery, and women's health care. A network of alternative health programs has emerged that tries to develop self-care and nonhierarchical, anti-capitalist forms of practice; these ventures then would provide models of progressive health work when future political change permits their wider acceptance(57,58).

In anti-imperialist organizing, several groups have assisted persecuted health workers and have spoken out against medical complicity in torture. Health and science workers also have used historical materialist epidemiology in occupational health projects and unionization struggles.

A common criticism of the Marxist perspective is that it presents many problems with few solutions. Clearly, however, this approach has clarified some useful directions of political strategy. This struggle will be a protracted one, and will involve action on many fronts. The present holds little room for complacence or misguided optimism. Our future health system, as well as the social order of which it will be a part, depends largely on the praxis we choose now.□

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THE RISING TIDE OF SOCIOBIOLOGY

The number of books on the Sociobiology shelf continues to grow, not too surprisingly, as apostles of the field increase their output of publications and critical analysts respond. In addition to E.O. Wilson's new book *On Human Nature,* David Barash has produced *The Whispering from Within,* while Lionel Tiger has come up with *Optimism: the Biology of Hope.* In addition, we have Mark Shapiro's *The Sociobiology of Homo Sapiens.*

If you're in the mood for a more "balanced" presentation, we now have Arthur Caplan's collection *The Sociobiology Controversy,* Ashley Montagu's *Sociobiology Examined,* and Peter Klopfer's *The Modern Roots of Sociobiology.* All three volumes contain articles by members of Science for the People or the study group. Critical reviews of Wilson's new book can be found meanwhile in the October issues of Psychology Today (by Ruth Hubbard) and Human Nature (by Steven Gould). Our critique will be in the next issue of SftP magazine. Meanwhile our Sociobiology packet (6 articles for $2.50) can offer an alternative to the tide of Sociobiology. Evidently, there is good reason to believe that the debate over Sociobiology will not abate for some time to come.

Sociobiology Study Group
Boston Science for the People

ABOUT THIS ISSUE, *continued from page 4*

sive struggles show. Yet, revolution is unlikely to occur in the near future, and in the meantime ways must be found that both politicize people and enable them better to fulfill their day-to-day needs within the present system.

* * *

Following independence from British Colonial rule, the government of the newly formed Tanzania proclaimed as one aspect of its path of socialist development a commitment to improving the health of all the people. The article by Walter and Gail Willett is a first-hand report on the philosophy, organization and techniques of health care being currently promoted and practiced in Tanzania. In this underdeveloped country, most of the people are rural subsistence farmers. Thus, in addition to the need to develop medical resources, there are serious logistical problems associated with improving health care. Many of the Western-trained physicians have either left or are unwilling to practice in rural areas. Tanzania has adapted much of the Chinese approach to health care both because of similar economic and physical requirements and restraints and because of similar political positions on the role and practice of health care.

* * *

All of these articles in this issue have a common theme of health care, and raise questions of the strategy and tactics of social change and the improvement of health. While progressive in the short run, can the gains made by the Chicago community group lead to further changes of a more revolutionary nature or will they inevitably be defused and coopted by a capitalist class unwilling to give up its power and control? Without having undergone a socialist revolution, can Tanzania rid itself of capitalist ideology and social relations not only as they are manifested in health care but in other areas as well? How can we take the analysis of the Worcester Ward article and use it, not only to inform people and change their thinking about the purpose of such institutions, but to begin to see it as part of a larger political-economic system of exploitation and oppression that must be overthrown? Indeed, the underlying issue raised here is the debate over revolutionary versus reformist socialism. It is our hope that these articles stimulate that debate.□

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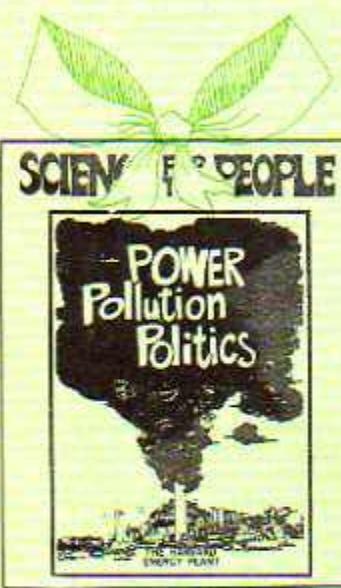
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Please send a gift card It should read:"From	Please send a gift card It should read:"From	Please send a gift card It should read:"From
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To: _____	To: _____	To: _____
Name _____	Name _____	Name _____
Address _____	Address _____	Address _____
_____	_____	_____
_____	_____	_____

Total $ enclosed: _____

Thanks! Please return to SftP, 897 Main St., Cambridge, MA 02139.