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The psychiatrist enters the scene.

sharp break with the past and a genuine advance for women: it was not physically injurious, and it did permit women to have sexual feelings (although only vaginal sensations were believed to be normal for adult women; clitoral sensation was "immature" and "masculine"). But in important ways, the Freudian theory of female nature was in direct continuity with the gynecological view which it replaced. It held that the female personality was inherently defective, this time due to the absence of a penis, rather than to the presence of the domineering uterus. Women were still "sick," and their sickness was still totally predestined by their anatomy.

THE "SICKENING" WOMEN OF THE WORKING CLASS

While doctors were manufacturing ills for affluent women, living conditions in the growing urban slums were making life actually hazardous for poor women. Tenements, which sometimes provided a single privy for dozens of families, were fertile breeding places for typhoid, yellow fever, TB, cholera, and diphtheria. Women who worked outside their homes often put in ten or more hours a day in crowded, poorly ventilated factories or sweat shops, with the constant danger of fatal or disfiguring industrial accidents.

A woman who worked in the garment industry between 1900 and 1910 described her working conditions as follows:

> I see again the dangerously broken stairways in practically all these so-called factories. The windows few and so dirty that rarely did the sun's rays penetrate these interiors. The wooden floors that were swept once a year. . . . No dressing rooms save the filthy, malodorous lavatory in the dark hall. No fresh drinking water save the cheap soda sold by the poor old peddler. Workshops wherein mice and roaches were as much a part of the physical surroundings as were the machines and the humans. . . .

Sickness, exhaustion, and injury were routine in the life of the working-class woman. Contagious diseases always hit the homes of the poor first and hardest. Pregnancy, in a fifth- or sixth-floor walk-up flat, really was debilitating, and childbirth, in a crowded tenement room, was often a frantic ordeal. Emma Goldman, who was a trained midwife as well as an anarchist leader, described "the fierce, blind struggle of the women of the poor against frequent pregnancies" and told of the agony of seeing children grow up "sickly and undernourished"—if they survived infancy at all. For the woman who labored outside her home, working conditions took an enormous toll. An 1884 report of an investigation of "The Working Girls of Boston," by the Massachusetts Bureau of Statistics of Labor, stated:

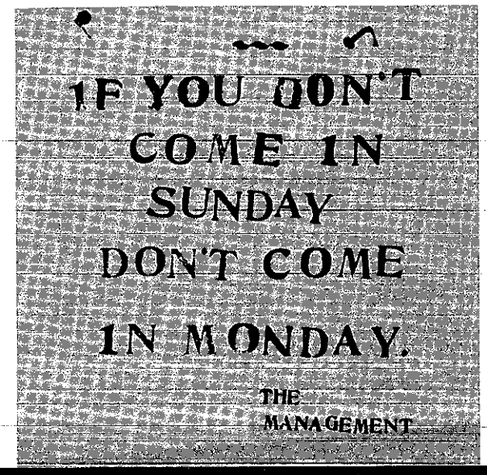
> . . . the health of many girls is so poor as to necessitate long rests, one girl being out a year on this account. Another girl in poor health

> was obliged to leave her work, while one reports that it is not possible for her to work the year round, as she could not stand the strain, not being at all strong. A girl . . . was obliged to leave on account of poor health, being completely run down from badly ventilated work rooms, and obliged to take an eight months rest; she worked a week when not able, but left to save her life. She says she has to work almost to death to make fair compensation (now $12 per week).

Still, however sick or tired working-class women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less for menstrual periods, though the wives of these same employers often retired to bed on all these occasions. A day's absence from work could cost a woman her job, and at home there was no comfortable chaise longue to collapse on while servants managed the household and doctors managed the illness. Two women who worked in the garment industry remembered:

> We only went from bed to work and from work to bed again. . . and sometimes if we sat up a little while at home we were so tired we could not speak to the rest and we hardly knew what we were talking about. And still, there was nothing for us but bed and machine, we could not earn enough to take care of ourselves through the slack season.

Doctors, who zealously indulged the ills of wealthy



patients, had no time to spare for the poor. Lillian Wald, a nurse who set up her own practice on New York's Lower East Side, wrote of the troubles she had in finding a doctor to visit a dying woman in the slums. When Emma Goldman asked the doctors she knew whether they had any contraceptive information she could offer the poor, their answers included, "The poor have only themselves to blame; they indulge their appetites too much," and, "When she [the poor woman] uses her brains more, her procreative organs will function less." By and large, medical care for the poor meant home remedies or patent medicines. Only those too far gone to protest would make the trip to a public hospital where inadequate nursing and unsanitary conditions actually diminished one's chance of survival.

Women's Ward in Bellevue Hospital

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Clinic Care for the Poor

If there was no public outcry about the health of poor women, there was a great deal of upper- and middle-class concern about what the poor were doing to the "health" of the cities.

Americans liked to pride themselves on having a classless society, but there was no way to ignore the fact of increasing class polarization in the cities, where the gracious homes of the affluent were often less than a trolley ride away from such notorious slums as New York's Hell's Kitchen or Lower East Side, or Boston's North Side. There had always been poor people, of course, but there had never been so many of them, and they had never been so visibly different from everyone else. Waves of immigration from southern and eastern Europe had created a working class that had its own distinct languages and customs. By the late nineteenth century immigrant workers outnumbered "native Americans" in the major industrial cities—New York, Cleveland, and Chicago. Cities that had once been peaceably middle class became scenes of epidemics, vice, municipal corruption, and—most frightening of all—riots and violent strikes. The causes of working-class unrest were easy enough to see, for anyone who wanted to see them, but it was simpler and more comfortable to blame the poor themselves. As disruption led to repression, and repression fueled new disruptions, wealthier people began to have a sense of being beleaguered in their own land—surrounded by the unwashed, unruly, "un-American" poor.

Immigrant Family

Class struggle—in the eyes of an increasingly smug and prosperous middle class—was unnatural, un-American, something that only happened "over there" in decadent Europe. Fortunately, "science" provided terms in which class polarization could be talked about without any damage to national pride. The main idea, that the poor were "naturally" inferior, was remarkably parallel to medical theories about women.

First, there was Darwin's theory of evolution, which conveniently hit the popular consciousness in the 1860s and 1870s, just in time to explain the developing class polarization. If some people had more than others—more money, more leisure, better housing, etc.—this was just another case of the workings of that great natural law: the survival of the fittest. It would be "unscientific" to see poverty as the result of social injustice when it was only Nature's way of singling out the manifestly "unfit."

In view of Nature's grand evolutionary purpose, the rebelliousness of the poor was, at best, short-sighted. More commonly, it was seen as an infraction of natural law, i.e., a disease. Contemporary metaphors of class struggle drew as heavily from medicine as from Marx. For example, a writer in

a business magazine declared just after the 1886 Haymarket riot that anarchy was a "blood disease" from which, apparently, only Americans of Yankee stock were exempt.

In 1885 a leading minister called for a rational approach to labor unrest, which was fundamentally "physiological" in origin. Race problems came in for the same treatment, the most farfetched example being Dr. Samuel A. Cartwright's pre-Civil War theory that the tendency of slaves to run away was due to a congenital blood disorder—which he dignified with the Latin name "drapetomania" (curable, needless to say, by hard work and whippings). Just as gynecologists found female restlessness to be a symptom of basic ovarian malfunction, so did social observers see the poor as a "race" afflicted with pathological rebellious tendencies.

Biological Class Warfare

Social Darwinism was a comforting ideology for those on top, but it never quite dispelled the fear that, by some irony of natural history, the poor might win out in the new *biological* class warfare. First, there was the danger of contagion from the poor. Disease was invariably seen as foreign in origin—imported on immigrant ships and bred in immigrant slums. In mid-century, an ex-mayor of New York wrote in his diary that the immigrants were:

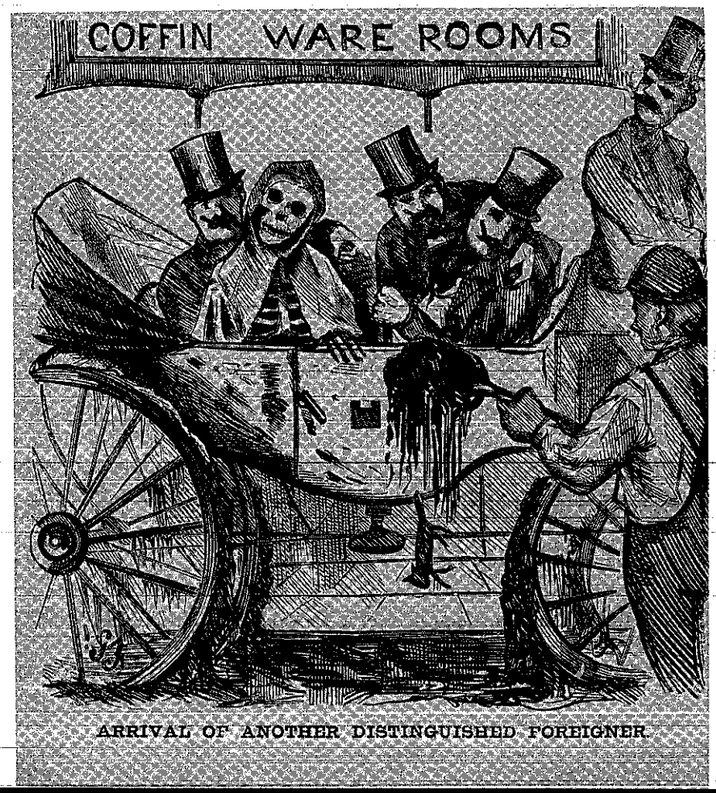
> filthy, intemperate, unused to the comforts of life and regardless of its proprieties. . . . [They] flock to the populous towns of the great west, with disease engendered on shipboard, and increased by bad

habits on shore, they inoculate the inhabitants of these beautiful cities.

In her household hygiene book (*Women, Plumbers and Doctors, or Household Sanitation*, 1885) Mrs. H.M. Plunkett warned:

> A man may live on the splendid "avenue," in a mansion plumbed in the latest and costliest style, but if, half a mile away, in range with his open window, there is a "slum," or even a neglected tenement house, the zephyrs will come along and pick up the disease germs and bear them onward, distributing them to whomsoever it meets, whether he be a millionaire or a shillingaire, with a perfectly leveling and democratic impartiality.

The germ theory of disease, which became known to the public in the 1890s (in a somewhat distorted fashion),



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ARRIVAL OF ANOTHER DISTINGUISHED FOREIGNER.

supplied a more concrete basis for class fears about contagion. No longer could abstract "filth," miasmas, or divine will be blamed for disease. There were real, material germs, transmitted by human beings and the objects they touched. Americans, who only a generation ago had feared that bathing was harmful, became preoccupied with germs. The reason people gave for avoiding the ghetto was not the risk of being mugged, but that of being infected with disease. In fact, any public place or object was suspect, as these popular magazine article titles from the period 1900 to 1904 suggest: "Books Spread Contagion," "Contagion by Telephone," "Infection and Postage Stamps," "Disease from Public Laundries," "Menace of the Barber Shop."

There was, certainly, some rational basis for the fear of the poor as a source of contagion. Rates of infectious diseases were higher among the poor, and since scientists themselves were not sure how germs were transmitted, it probably seemed safest just to avoid contact with the poor as much as possible. But for our purposes, the distinction between intelligent caution and outright prejudice is not very important. The point is that middle- and upper-class people frequently *expressed* their fear of the poor as a fear of germs, just as white people today might say they don't mind contact with blacks per se; it's crime (or drugs) they're afraid of.

The second front in the biological class warfare featured not germs, but genes. An optimistic reading of Darwin suggested that the "better" class of people would soon outnumber, as well as dominate, the less fit. Poverty was its

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own cure; epidemic diseases among the poor were the ultimately benign instrument of natural selection. (In the 1870s an observer pointed out that the race problem would soon solve itself. Living in abject poverty in northern cities, freed slaves seemed to be rapidly headed for extinction.) But by the turn of the century it began to seem as if, by some monstrous aberration of natural law, the *better* classes were doomed for extinction.

The birthrate among WASP Americans had been falling since about 1820. Immigrants and blacks, despite their much higher death rates, were believed to breed prolifically. Edward Ross, an early twentieth-century writer who was a liberal for his time, connected the immigrants' fecundity to "their coarse peasant philosophy of sex," "their brawls and their animal pleasures." All this was abhorrent to people of delicacy, but so was the prospect of extinction.

A Professor Edwin Conklin, of Princeton, wrote in the 1890s:

> The cause for alarm is the declining birth rate among the best elements of a population, while it continues to increase among the poorer elements. The descendants of the Puritans and the Cavaliers . . . are already disappearing, and in a few centuries at most, will have given place to more fertile races. . . .

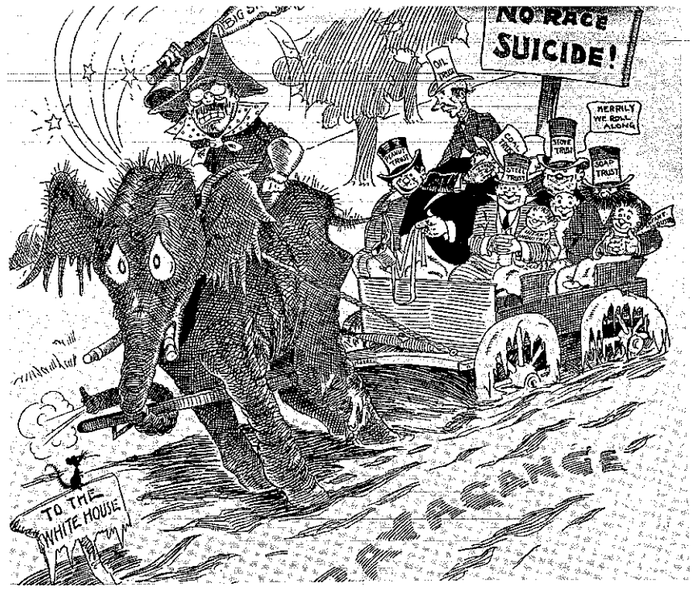
In 1903, President Theodore Roosevelt thundered to the nation the danger of "race suicide":

> Among human beings, as among all other living creatures, if the best specimens do not, and the poorer specimens do, propagate, the type [race] will go down. If Americans of the old stock lead lives of celibate selfishness . . . or if the married are afflicted by that base fear of living which, whether for the sake of themselves or their children, forbids them to have more than one or two children, disaster awaits the nation.

He was not against contraception on principle, granting that "doubtless there are communities which it would be in the interest of the world to have die out," but for middle- and upper-class WASP women, it was downright unpatriotic.

The Special Danger of Working-Class Women

As strikers, rioters, or terrorists, working-class men were



usually at the forefront of overt political class struggle. Working-class women, on the other hand, were seen as leading the insidious biological warfare. As breeders, they seemed to outdo the delicate or "high-strung" ladies of the better classes. As disease carriers, they were regarded as especially dangerous because they were likely—much more than working-class males—to come into close contact with affluent people. While the men were safely quarantined in heavy industry, the women sought jobs in some of the niches left by leisured females of the middle and upper classes. "Ladies" no longer did their own sewing or housekeeping and were far too well mannered to satisfy their husbands' sexual appetites. So fields such as domestic service, garment manufacture, and prostitution were wide open to working-class women.

Wherever working-class women, or their products, entered the homes of the "better" classes, could germs be far behind? Garments sewn in tiny tenement sweatshops were suspected of carrying disease germs into wealthy homes, and the garment workers' union played up to this fear by urging people to buy union label clothes because they were made in "hygienic" factories rather than unsupervised tenement

shops. The winner of the American Federation of Labor's essay prize on "The Union Label" (c. 1912) wrote: "The union label is, indeed, the only guarantee that the products of any industry are fit to enter decent and cleanly homes." What the union had in mind, of course, was that consumers' interest in hygiene would lead them to support the workers' cause, but this strategy sometimes backfired. AFL President

Samuel Gompers complained in 1903 that certain consumer groups composed of "well-meaning philanthropic ladies" were issuing their own labels on the basis of sanitation alone, with no regard for the wages, working conditions, or hours of the women workers, and sometimes even in competition with the workers' own label!

Domestic servants, "the strangers within our gates," were not so easily disposed of. One couldn't do without them, but could one trust them? A survivor of the early decades of the twentieth century told us: "If anything was missing, like a piece of silverware, the servants must have taken it. If anyone in the family got sick, you naturally suspected the servants of carrying something."

The case of "Typhoid Mary" riveted public attention on the dangers of contagion from domestic servants. From a brief account of this case one can appreciate its dramatic impact.

Mary Mallon was an Irish-American cook who worked the silk-stocking districts--Oyster Bay, Park Avenue, Sands Point, Dark Harbor, Maine. Her references were good, her employers liked her cooking and were frequently impressed by her

steadfastness in the face of family disaster, which seemed to be a routine feature of Ms. Mallon's working life.

When she was finally locked up in 1915, she had left a trail of fifty-two typhoid cases, three of them fatal, in the homes of her employers. Her employers had always tended to blame some other servant in their houses for the typhoid outbreaks, until the relentless detective work of the New York City Health Department exposed Ms. Mallon as the culprit. The lab tests proved it: She was a typhoid germ carrier who did not herself suffer from the disease. She was first apprehended in 1907 and placed in solitary quarantine on a tiny island in the East River, then after three years released on parole on the condition that she give up cooking. In 1913 she broke parole and vanished, only to turn up two years later—cooking again—in a Queens hospital struck by typhoid.

Ms. Mallon always insisted that she had never had typhoid fever, was not a typhoid carrier, and was the innocent scapegoat of publicity-hungry health officials. When the health officials came to get her in 1907, she first resisted with a carving fork, then escaped through a back window and barricaded herself with barrels. She was whisked off by car to the public health laboratory with eminent public health author-

ity Dr. Josephine Baker sitting on her chest to subdue her. Her final capture in 1915 was, according to the New York Times, *"nearly as lively as her first one," featuring another chase through windows and backyards.*

Here was biological guerrilla warfare at its most virulent. Newspapers' Sunday supplements caricatured Ms. Mallon as a fiend popping human skulls into a skillet while the *New York Times* solemnly explained the dangers of hiring servants without thoroughly investigating references. Typhoid Mary survived in folklore as a symbol of the "sickening" woman who poisons everything she touches.

Of course, we now know that, as a typhoid carrier, she was a medical anomaly, a weird exception. Yet to middle-class people of her day she epitomized the threat that *all* working-class women represented: they might *look* innocently robust and healthy, but who knew, finally, what dread disease they harbored.

Prostitutes and Venereal Disease

Although servants and working-class women in general were all faintly suspect, no one excited middle-class germ

fears like the prostitute. Prostitution represented a reservoir of hideous disease, perpetually spilling over into the families of decent people: infecting the fetus in the womb, crippling innocent wives, and dragging the erring males to ruin. Prostitution had not been a problem in the nation's youth, but urbanization and poverty made it a booming industry in the late nineteenth and early twentieth centuries. To reform-minded citizens (many of them women's rights activists), prostitution was much more than a public health problem, it was *the* Social Evil, underlying municipal corruption, family breakdown in the lower classes, and public immorality in general.

Some of the best data we have on the extent of prostitution and VD during the first decades of the century come from a series of studies sponsored by John D. Rockefeller Jr.'s Bureau of Social Hygiene (a private, voluntary agency). According to one of the Bureau reports, prepared by Dr. Howard Woolston, alarm reached a peak in the 1910s when the prospect of U.S. involvement in the First World War "brought home to the American people as nothing in our previous history had ever done, the menace of

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Police Raid on a Brothel

prostitution and venereal diseases to the young manhood of our country."

By 1917 (the date of this report), police efforts had already cut severely into the trade, and yet Dr. Woolston found 200,000 women "in the regular army of vice," an estimated 60 to 75 percent of them carrying VD. As a result, an estimated 25 to 35 percent of the adult urban population were infected. Not only laboring men with their "animal pleasures," but also businessmen, college boys, and professional men were among the victims.

Only the most enlightened—feminists and social reformers—traced prostitution to poverty and oppressive sex roles. Moralists blamed "male lust and female frailty." More "scientific" observers blamed the prostitute herself or, rather, her "congenital defects." In the 1917 study Dr. Woolston went out of his way to discount economic motivations in prostitutes, and seriously concluded that "the ordinary prostitute appears to be a short, stocky woman." Further, at least one third of them were mentally defective:

> It is a well-known fact that feeblemindedness is hereditary. Consequently, some of the mental anomalies of the prostitutes can be directly traced to weakness in the stock from which they come. . . . In 297 of the 1,000 families [of prostitutes surveyed] . . . some actively vicious or clearly recognized degenerate strain was

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Death Posing as a Female Peddler in the Slums of New York (1882)

known to be present. It is likely that a more complete investigation would have revealed an even larger number.

However, prostitutes were not seen as a breed apart from the average working-class woman. Dr. Woolston and other surveyors found that there was considerable shuttling back and forth between prostitution and low-paid jobs such as domestic service. In the popular imagination, working-class women were all somewhat sickening, whether because they spread diseases or dragged down the "race" with their inferior and all-too-plentiful offspring. If the upper-middle-class woman had health problems, the working-class woman *was* a health problem. Not for her the domineering and indulgent physician; for her there was the public health officer.

The Middle-Class Offensive: Public Health

Beginning in the last decades of the nineteenth century, the "better" classes launched an organized political offensive against poor and working people. There were repressive anti-labor measures, civic "reforms" aimed at reducing the electoral power of immigrant groups, and, later, laws to stop the immigration of Italians, Jews, Poles, and other "inferior" races. In the *biological* class warfare, the two major middle-class thrusts were the public health movement and the birth control movement, directed against the twin threats of

contagion and "outbreeding," respectively. Both of these movements drew heavily on the energies of middle- and upper-middle-class women who, as our historical period wore on, were becoming increasingly dissatisfied with the life of enforced leisure.

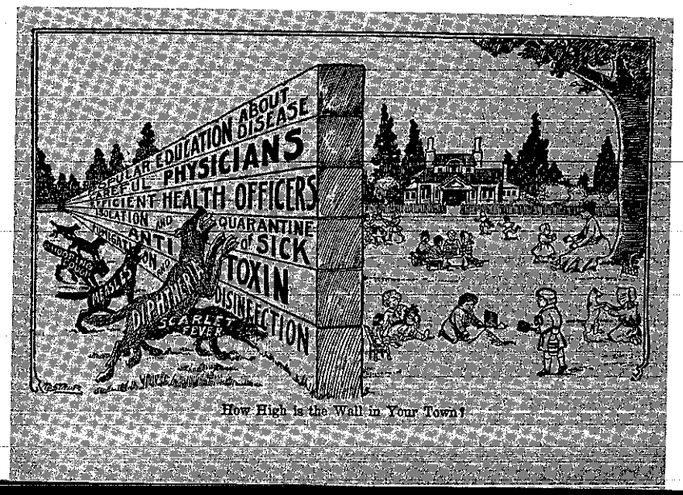
The progressive achievements of these movements are obvious: legal contraception, free garbage removal, compulsory immunization, to name just a few. But their story as social movements is somewhat more ambiguous: both mobilized large numbers of middle- and upper-class women in a way which solidified their new relationship to working-class women—not as sisters, but as *uplifters.*

The public health movement had an evangelical tone which put it in the same moral league with the temperance and "social purity" (anti-prostitution) movements. In fact, the distinction between "dirt" and "sin" was still unclear. An earlier generation had traced all disease to immorality and relied on prayer rather than sanitation to ward off epidemics. The sin theory of disease provided a comforting explanation of why epidemics were most virulent in the areas inhabited by "vicious, intemperate, and atheistic" immigrant workers. But the theory was not so comforting when it became clear

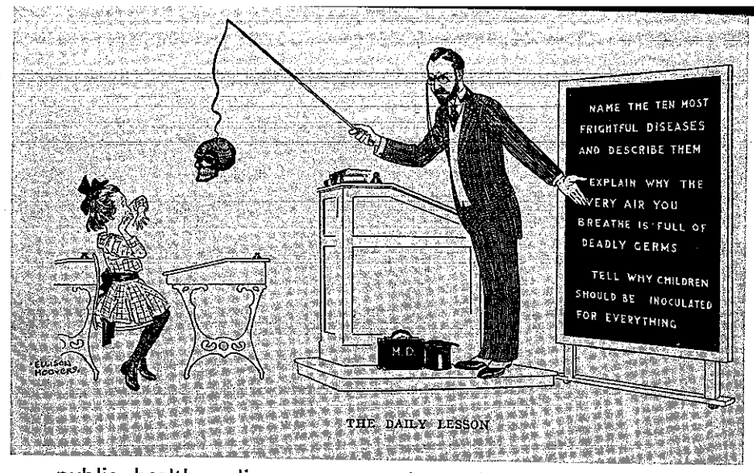
that epidemics could also carry off bankers, ministers, and society ladies. The blame shifted from sin to "dirt," but the moral implications hardly changed. Typhoid epidemics, according to the household hygiene book we cited earlier, had been looked upon as "chastening visitations of God for moral delinquencies," but, in the light of contemporary sanitary "science," were recognized as "the strict adjustments of penalty for His broken physical laws." Dr. Elizabeth Blackwell called sanitation "the *reverential* acceptance of the *divine* laws of health" (emphasis added).

The moral aspect of public health was also reflected in its strong bureaucratic ties to the police. In New York City, which set the pattern for public health administration in other cities, public health was originally a police function, and the first Metropolitan Board of Health included equal numbers of doctors and police officials. The association between public health and police functions (crime and disease) was strengthened by the realization in the latter part of the first decade of the twentieth century that people—not books, coins, or breezes—were the main carriers of disease. Then public health officers began to take on police functions themselves, tracking down and quarantining (as in the case of Typhoid Mary) characters suspected of spreading disease. The crime-fighting zeal of the public health officials comes through clearly in a 1910 article in *The Nation*, calling for

Public Health Poster (1910)



How High is the Wall in Your Town?



THE DAILY LESSON

public health police powers to hunt down an estimated 20,000 "loose" TB victims:

> It is as if the enemy had stolen through the pickets at night and there were no police or soldiers to follow them. The tubercle bacilli swarm through the city on silent wings, grimly laughing at the pamphlets and lectures and scattered deeds of charity which they find so easy to elude.

Public health crusaders were perfectly frank about their class interests in reform. The National Association for the Study and Prevention of Tuberculosis presented detailed calculations of the costs of TB among the poor to the middle class—in terms of absenteeism by workers, relief required for orphans, etc. In a more lyrical vein, Mrs. Plunkett, the household hygiene expert, asked how the problem of poverty and disease was to be solved, and answered her own question:

> Through the agency of *enlightened selfishness* . . . the upper 10,000 are learning that their sanitary welfare is indissolubly connected to that of the lower 10 millions, and it is this perception of this truth that has caused the "wave of emotional interest" in the condition of the poorer classes. . . . The class to be elevated resent supervision and care little for health or cleanliness till taught but already some great and definite steps have been taken.

In the war against dirt and germs it was only natural that women should take the lead. Weren't women the divinely

appointed sanitation officers of their own homes? In 1881 an American household hygiene book quoted the president of the British Medical Association (at the time probably more prestigious here than the AMA) as placing almost full responsibility for health on "the character of the presiding genius of the home, or the woman who rules over that small domain." But woman's sanitary responsibilities obviously could not end at her doorstep. In his thesis on nineteenth century "social purity" movements, David Pivar writes:

> Women of the middle class believed in high standards of sanitation and cleanliness and feared the contagions located in the slums and on the streets. Long dresses, dragging the muck, transported dirt, dust and germs into the home. Clothing manufactured in tenement

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Board of Health Raid on a Tenement

houses found its way into middle class homes. Disease could not be stopped with a closed door. If the home was to be protected, women could not turn inward; they were forced to make the community more "home-like." Only through improvements in public health and morals could the sanctity of the home be assured.

Women doctors entered public health in disproportionate numbers (partly because it was easier for a woman to enter public health than to set up in private practice). At the grass-roots level, public health was very much a women's movement (of upper-middle-class women) with close ties to the temperance and suffrage movements.

The Middle-Class Offensive: Birth Control

Public health was always respectable, but the birth control movement started out in the disreputable company of anarchists, socialists, and extreme feminists. Emma Goldman was jailed for speaking on birth control, and the young Margaret Sanger pushed it in her socialist/feminist journal *The Woman Rebel.* At first, other middle-class reformers

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Margaret Sanger Selling Her Birth Control Review *in the Streets of New York, 1915*

saw birth control as a wicked scheme to "take the penalty out of vice," and "degrade the wife to the level of the prostitute."

But as the movement matured under Sanger's single-handed leadership and attracted the support of thousands of upper-middle- and upper-class women, it began to make a frank appeal to upper-middle-class self-interest. By the late 1910s Sanger was blaming all the problems of the world—war, poverty, prostitution, famine, feeblemindedness—on overpopulation, and she put the blame for overpopulation squarely on women:

> While unknowingly laying the foundations of tyrannies and providing the human tinder for racial conflagrations woman was also unknowingly creating slums, filling asylums with the insane, and institutions with other defectives. She was replenishing the ranks of prostitutes, furnishing grist for the criminal courts and inmates for prisons. Had she planned deliberately to achieve this tragic total of human waste and misery, she could hardly have done it more effectively.

And in case that did not make clear *which* women Sanger blamed, she wrote, in 1918, that "all our problems are the result of overbreeding among the working class."

Birth control offered the possibility of qualitative as well as quantitative control of the population. "More children from the fit, less from the unfit—that is the chief issue of birth control," Sanger declared in 1919. Just who was fit and who was unfit—and how you would impose birth control on one group and keep it away from the other—was not altogether clear. Ms. Sanger usually limited her definition of the "unfit" to the feebleminded (as judged by the newly invented IQ test), but some of her associates in the American Birth Control League were explicitly racist.

Guy Irving Burch, an officer of Sanger's National Committee on Federal Legislation for Birth Control, explained his interest in birth control thus:

> My family on both sides were early colonial and pioneer stock and I have long worked with the American Coalition of Patriotic Societies to prevent the American people from being replaced by alien or Negro stock, whether it be by immigration or by overly high birth rates among others in this country.

Another birth control advocate urged that "to offset the so-called 'yellow peril,'" the United States should, "spread birth control knowledge abroad so as to decrease the quantity of people whose unchecked reproduction threatens international peace."

A few farsighted physicians joined in the campaign to make contraception acceptable to the middle class by pointing out its possibilities for population control. In his 1912 presidential address to the AMA, Dr. Abraham Jacobi endorsed birth control, citing the high fertility of immigrants and the rising cost of welfare. Dr. Robert Dickinson, a gynecologist and one of Sanger's most steadfast medical allies, urged his fellow doctors in 1916 to "take hold of this matter [birth control] and not let it go to the radicals." With the help of men like Dr. Dickinson, Ms. Sanger was able to begin the first birth control services—appropriately enough, in the slums of New York City.

Contraception did not become legal until a 1938 court

ruling allowed physicians to import, mail, and prescribe birth control devices. This was a great step forward for women, and the credit goes largely to Margaret Sanger's courage and determination.

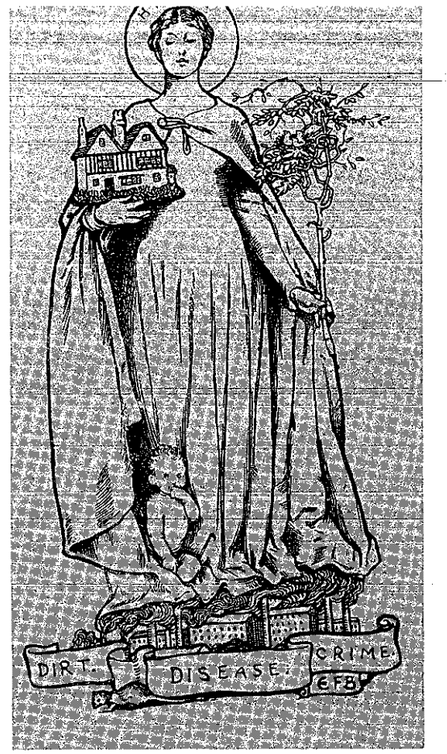
We want to be clear about our position on this issue. We think birth control should be available on demand for all *women, of all classes and ethnic groups. We do not subscribe to the view that birth control is liberating for some women, but "genocidal" for others. What we are criticizing is the line that the birth control movement advanced in order to make its gains. The fact that the birth control movement took a* racist *and* classist *line makes even the final victory a dubious one.*

But here we must ask ourselves: Could the birth control movement have succeeded any other way, given the context of American society at the time? If the birth control movement had advanced purely feminist arguments for contraception, would it have had the power or influence to succeed? We might ask a similar question about the public health movement: Would there have been any *public health reforms if these had not been in the direct self-interest of wealthy and powerful people? These questions are, of course, unanswerable, but they do point to the fundamental ambiguity of* reform *in an otherwise oppressive society.*

Women "Uplift" Women

The public health movement never succeeded in quarantining all the germ-ridden ghetto residents, and the birth control movement fell far short of its goals of race "purification." In fact, public health measures made the cities healthier for the poor as well as for the rich, and birth control, ironically, had its biggest impact on the population of the middle and upper classes themselves. Certainly, we owe a great deal to the masses of women who worked in these two movements, whatever their motivations. The sad thing is that the reform movements served to deepen the division of women along class lines: on the one side were the reformers (middle- and upper-middle-class women), on the other side the objects of reform (working-class women).

The reformers were women who rebelled against the empty leisure required of "ladies." They wanted to *do* something, wanted a project worthy of their untapped moral



sensitivities and social concerns. For many, that project became the great task of "uplifting" working-class women. Public health and birth control were the more impersonal part of the campaign; many women reformers were drawn into direct contact with poor women. Anti-vice crusaders attempted to reform prostitutes; social workers went into the slums to teach the poor home economics and "American values"; clubwomen set up discussion groups on ethical issues for young working women. According to home economics books of the time, even the woman who stayed at home had a missionary responsibility to instruct her servant in moral and sanitary matters and to prepare her to be a "good wife."

The upper-middle-class woman activist of the 1890s and early twentieth century had left her sisters far behind on their chaise longues, in sick rooms and health spas. She had rejected a medical ideology that defined her as sick and

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Wealthy women visit the sick poor.

confined her to uselessness. But she seems to have won her "release" only on condition that she both remain true to the interests of her class and take on social roles that were essentially extensions of the wife/mother role, as social worker or volunteer "uplifter." In these roles, bringing the gospel of hygiene, public health, home economics, etc. to the poor, she was necessarily patronizing, at times antagonistic, in her relations with poor women.

The issue of health—female health and family health—which potentially could have united women of different classes, now divided them into reformers on the one side and "problems" on the other. Upper-middle-class women did not turn against the medical profession that had imprisoned them and rejected poor women; they did not unite with poor women to create a movement which could demand a single standard of health and health care for all women. In the public health and birth control movements they allied themselves *with* doctors, against the threats posed by the poor.

However, we do not want to leave the impression that upper-middle-class women were simply "led astray," by ideological considerations, from the task of building a health movement for and with all women. It is true that women of all social groups have a potential unity around common biological experiences. And it is true that medical ideology—in the form of both "scientific" theory and popular beliefs—did its best to deny the commonality of women's experience and to separate women into the sick (or vulnerable) and the sickening (or dangerous). But this ideology would never have been accepted by men—or women—of the upper classes if it hadn't been rooted in economic reality.

In many ways, the situations of women in the classes we have considered were complementary. Upper-middle-class women would not have had the leisure to be invalids, or reformers, if it had not been for the exploitation of working-class people (including women and children); they would not have been free from household work if it had not been for the labor of domestic servants and the women who worked in factories manufacturing clothes and other household items that had once been made in the home. Medical myths and biological fears did not create the class differences among women; they only gave them "scientific" plausibility.

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DISTRIBUTING FLOWERS AND PERIODICALS IN THE WOMEN'S WARD, CONVALESCENT HOSPITAL.

Mad Magazine's View of Women

NOTES ON THE SITUATION TODAY

One hundred years have passed since the heyday of wholesale ovariotomies, hysteria, and enforced invalidism. Medical theory no longer asserts that some women are congenitally sick, while others are potentially sickening. Yet in some important ways, the relationship between women and the medical system has changed very little, if at all.

Middle-and upper-class women are still a "client caste" to the medical profession. For a host of reasons connected with reproductivity women continue to visit doctors and enter hospitals far more frequently than men do. Pregnancy, if no longer described explicitly as a disease, is still treated like a medical problem, in exactly the same settings and by exactly the same personnel used for the treatment of actual disorders. Childbirth is no longer a cause for lengthy confinement, but it is, more so than ever, an alienating,

surgical event. Irregular menstruation is no longer viewed as calamitous, but doctors are more than willing to provide costly hormonal "cures." Menopause, while no longer an indication for terminal bed rest, is still described to medical students as "the most serious endocrinological disorder next to diabetes," "curable" of course, with expensive estrogen therapy. And while the riproaring frontier days of gynecological surgery may be gone forever, some doctors, such as Robert McCleery, in *One Life, One Physician* (1971), acknowledge that up to half of the hysterectomies performed in the United States (and perhaps a large proportion of radical mastectomies* performed anywhere) are unnecessary.

In fact, women's dependence on doctors (hence doctors' dependence on women) may have increased since 1900. Doctors moved in on each sexual or reproductive right as soon as it was liberated: they now control abortion and almost all reliable means of contraception. Even sexual unresponsiveness—the "natural" condition of our great-grandmothers—has become a medical problem, with its own sex "clinics" and its own brand of medical specialists.

There are still profound class differences in women's relationship to the medical system. On the medical marketplace millions of women—far more than the statistically "poor"—cannot afford the most basic, preventive services, never mind the luxury items. The fragmented pattern of public health services for low-income women—here a VD clinic, there a Planned Parenthood clinic, almost nowhere a low-cost comprehensive care center—shows that they are still treated more as public health problems than as human beings needing individualized medical care. For no groups is this truer than for black, Puerto Rican, and Chicana women. Once lumped together with Italians, Poles, and other immigrant groups as "inferior stock," Third World women now stand almost alone as the special target of such population control measures as involuntary sterilization.

We could go on tracing continuities from the nineteenth and early twentieth centuries, but we are struck even more by the differences. The situation of both doctors and women has changed drastically. For women, even in the upper middle class, the days of total leisure are over. More and more women work outside the home, and, within the home,

* Mastectomy is the surgical removal of the breast. Some mastectomies involve considerable damage to the muscles around the upper arm.

Clinic Waiting Room

the servants are gone. The woman who works outside holds down two jobs—that of a paid worker and that of an unpaid housekeeper and mother. Even the more affluent, "leisured" housewife is expected to be healthy and active at all times, able to chauffeur the kids around, manage the house, and perform as a gracious wife and hostess. In a statement that speaks for almost all of us, one working-class housewife told a medical sociologist, "Sometimes I'd like to be sick, but I don't have the time."

Doctors today don't seem to have the time for us to be sick anymore either. In the late nineteenth century there was, by present standards, an excess of doctors in the cities. Competition was fierce, and there was a strong motivation to over-treat ill women and discover illnesses among well women. But in the early 1900s the medical profession won the legal right to control its own numbers—to set standards for medical schools, close "substandard" schools, etc. (See our pamphlet *Witches, Midwives and Nurses* for more on this phase.) The closing of medical schools in the teens and twenties, followed by decades of AMA lobbying against Federal aid to medical schools, eventually produced the familiar doctor shortage. Only a few doctors base their practices on intimate care given to a small number of rich

people. Most spread their services fairly thinly over a large number of middle- or working-class people. The result is the ten-minute gynecological appointment, the fifteen-minute annual checkup (these are the actual times allotted in one of the New York area's largest and most reputable group practices), and during such quickie examinations the amount of patient/doctor dialogue is reduced to a minimum.

So for most of us, the intimate, paternalistic doctor-patient relationship of the nineteenth century is little more than a historical curiosity. Being sick is no longer consistent with our social roles nor is it a practical possibility, given the doctor shortage. Our medical image has come almost full circle from the days of female invalidism. Because women have longer life expectancies than men, with lower risks of heart disease, stroke, and lung cancer, *we* are considered the "stronger" sex, and the popular health books eagerly advise us how to keep our *husbands* alive and well. Just as surely as ever, our medical care does serve to enforce our social role, only now that role is to be workers (domestic or otherwise), not pampered invalids.

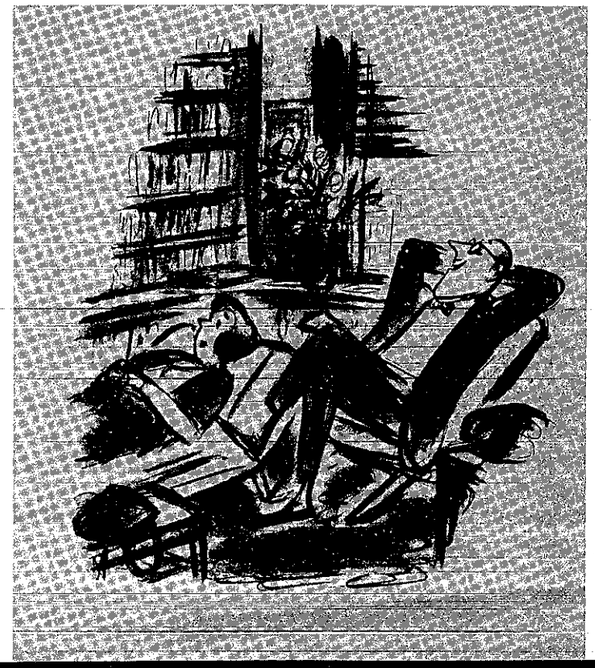
When a doctor cannot quickly pinpoint the organic cause of a woman's complaint, he is quick to suspect psychosomatic causes, i.e., malingering. A 1973 study written by two doctors, Jean and John Lennane, and published in a prestigious medical journal, concluded:

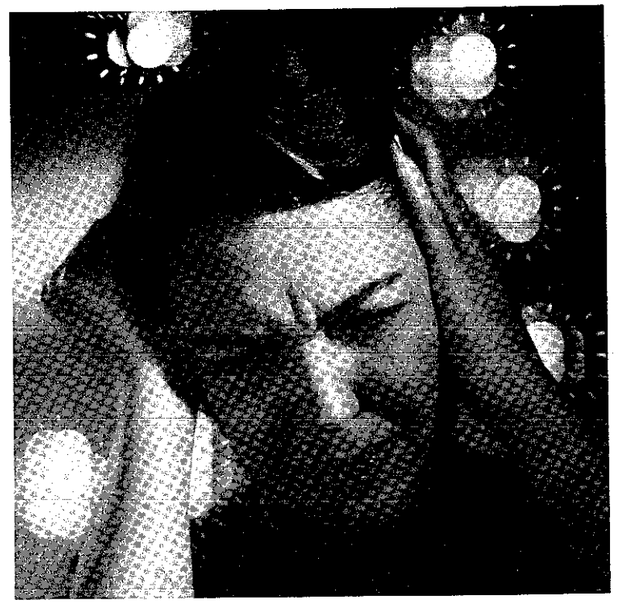
> Dysmennorhea [menstrual cramps], nausea of pregnancy, pain in labor and infantile behavioral disturbances are conditions commonly considered to be caused or aggravated by psychogenic factors. Although such scientific evidence as exists clearly implicates organic causes, acceptance of a psychogenic origin has led to an irrational and ineffective approach to their management. Because these conditions affect only women, the cloudy thinking that characterizes the relevant literature may be due to a form of sexual prejudice.

The medical profession helped to create the popular notion of women as sickly in the first place: now it seems to have turned around and blamed the victim. Women patients are seen as silly, self-indulgent, and superstitious. Tranquilizers are used to keep us on the job when no quick medical fix can be found. How many times do we go to a doctor feeling sick and leave, after a diagnosis of "psychosomatic," feeling *crazy*?

In fact, the tendency of doctors to diagnose our complaints as psychosomatic shows that the medical view of women has not really shifted from "sick" to "well"; it has shifted from "physically sick" to "mentally ill." Today it is

"Don't give it a second thought, Miss Watkins. <u>All</u> my patients are crazy about me."



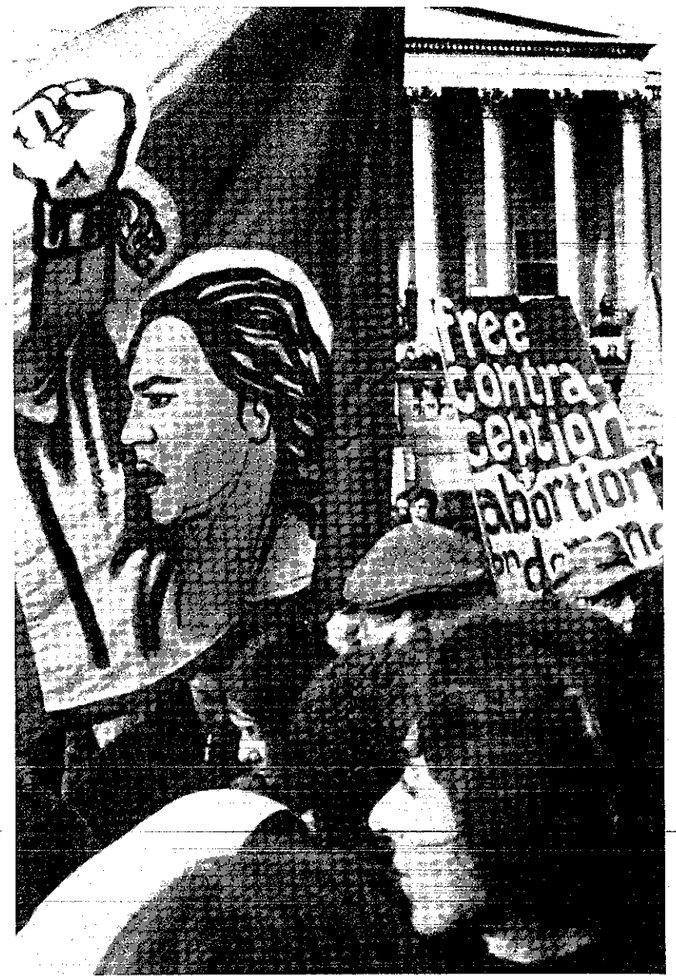


psychiatry, much more than gynecology, that upholds the sexist tenet of women's fundamental defectiveness. In classical psychoanalytic theory there is no such thing as a mentally well woman: the ambitious woman, not content to be a wife and mother, is seen as neurotically rejecting her femininity while the woman who is content to be with her family may be viewed as "infantile." Both are potentially sickening to those around them. The ambitious woman can be blamed for "emasculating" men, and the devoted mother can be blamed for "infecting" her sons with guilt and dependency. One result, as Phyllis Chesler has shown in her book *Women and Madness* (1972), is that women are more likely than men to be incarcerated in mental hospitals.

In general, the mainstream of psychological theory still

upholds the view that middle-class women should stay at home, but for new reasons. In the past, gynecology justified women's confinement to the home on the basis of women's supposed physical frailty and unfitness for outside pursuits. But now that middle-class women are finally sturdy enough to go out to work, they are being told that their children are too "delicate" to be left behind. Psychology has "discovered" that at least up to the age of three, children are totally dependent on one-to-one mothering! Send your child out to day care or hire a babysitter and you supposedly inflict a risk of lasting neurosis. (Pediatricians add that day care centers are notorious for spreading infectious diseases.) So now it is the small child of the middle-class woman who has become too "delicate" for the "outside world" of day care, babysitters, and play groups. In constrast, the children of welfare mothers—who *ought* to be out working, according to current moral standards—are emotionally sturdy enough for the most alienating, industrial-style day care centers.

We can only marvel at the endless plasticity of a medical "science" that can adjust its theories for age, sex, or social class, depending on the needs of time. Certainly, science, to *be* science, must change its theories to fit new data. What is amazing about medical "science" as it relates to women is that the theories change so neatly to fit the needs of the dominant, male ideology.



FROM HERE ON: CONCLUDING THOUGHTS

▫ The medical system is not just a service industry. It is a powerful instrument of social control, replacing organized religion as a prime source of sexist ideology and an enforcer of sex roles. Certainly, it is not the *only* haven of institutional sexism in our society—the educational system may be equally important or even more important. But it has the unique authority to judge who is sick and who is well, who is fit and who is unfit. The presumed scientific basis of medicine lends credibility to these judgements, yet as we have seen, the judgements themselves have no consistent basis in biology. At one time, women of one class were judged uniformly sick while women of another class were uniformly well though potentially sickening to others. Today we are all well, at least well enough to work; our sickness is "only mental." Our social roles, and not our innate biology, determine our state of health. Medicine does not invent our social roles, it merely interprets them to us as biological destiny.

▫ As feminists we are totally antagonistic to the medical system as a source of sexist ideology. But at the same time, we are totally dependent on medical *technology* for some of the most basic and primitive freedoms we require as women—freedom from unwanted pregnancies, freedom from chronic physical disability. We may be repelled by the crude sexism we encounter in doctors, we may be enraged by the sophisticated sexism passed off as medical theory, but we have nowhere else to turn for abortions, diaphragms, antibiotics, and essential surgery.

Our sheer physical dependence on medical technology makes the medical system all the more powerful as a source of sexist ideology. They have us, so to speak, by the ovaries. All too often, women have humbly accepted the ideological judgements ("you are sick, silly, hysterical, inadequate," etc.) as the price of whatever technological freedoms they could wrest from the system. Now that we have come to take these freedoms just a little bit for granted, we sometimes lean too far the other way—rejecting the technology itself because we cannot stomach the ideological wrapping.

□ So we seem to be caught in a contradiction: there is something in the medical system that we want, that we cannot live without, but is there any way to get it on our own terms? When we make demands of the medical system, or of a particular health institution, just what is it that we want? Do we want just "more services"—when every one of them is loaded with a message of oppression? When these services may have little to do with our real needs, and may in fact discount our real needs or substitute medically manufactured needs?

Clearly, our demands must go beyond the merely quantitative. We want more than "more"; we want a new *style*, and we want a new *substance* of medical practice as it relates to women. And yet we must never get so hung up on the ideological niceties that we forget that "more" alone is still crucial—an issue of survival—for millions of women who still lack the most routine care and preventive services, and who cannot function fully as women until they have them.

□ It is only in the context of our ambivalance to the medical system that we can assess the historic importance of the self-help movement.

Self help, which emphasizes self-examination and self-knowledge, is an attempt to seize the *technology* without buying the ideology. Self help has no limits beyond those imposed by our imagination and our resources. It *could* expand far beyond self-examination to include lay (though not untrained) treatment for many common problems—lay prenatal and delivery assistance, lay abortions, and so on. But if our imaginations are unlimited, our resources *are* limited. If we are concerned with the care of *all* women—and not just those with the leisure for self-help enterprises—for *all* their problems—and not just the uncomplicated disorders of

From Sister, *the Newspaper of the Los Angeles Women's Center (July 1973)*

youth—then we are once again up against the medical system with its complex and expensive technology.

In fact, it is in precisely this confrontation that self help proves its worth. It arms us to demand what we need, not what someone thinks we should get. It gives us a vision of what medical care *could* mean—a system in which needs are not met at the price of dignity.

Self help is not an alternative to confronting the medical system with the demands for reform of existing institutions. Self help, or more generally, self-knowledge, is critical to that confrontation.

□ Health is an issue for women which has the potential to cut across class and race lines. The medical system, more than any other institution of American society, reduces us to a biological category, stripped of our occupations, life styles, and individualities. There is very little danger today that middle-class women will relate to poor and working-class women purely as missionaries or "organizers" for health reforms because middle-class women are becoming so acutely

aware of their *own* oppression in the medical system. The growth of feminist consciousness gives us the possibility, for the first time, of a truly egalitarian, mass women's health movement.

But it would be naive to assume that, because all women experience medical sexism, all women have the same needs and priorities at this time. Class differences in the medical treatment of women may not be as sharp as they were eighty years ago, but they are still very real. For black women, medical racism often overshadows medical sexism. For poor women of all ethnic groups, the problem of how to get services of any kind often overshadows all qualitative concerns. And for all of us except the most affluent, there is the constant worry about whether the care we are getting meets minimal standards of technical competence—never mind the amenities of dignity and courtesy.

A movement that recognizes our biological similarity but denies the diversity of our priorities cannot be a women's health movement, it can only be *some women's* health movement. For example, it is important to demand a more dignified and participatory approach to childbirth. But to focus on the demand that we be allowed to experience the

beauty of childbirth—while thousands of women do not have adequate prenatal nutrition, or have not had access to the means of avoiding unwanted childbearing—is worse than naive: it is cruel.

□ It is easy enough to say that we must recognize the diversity of women's needs, and that the demands we make of the medical system must represent the broadest possible range of women's experience. But once we begin to talk about needs beyond the most minimal survival services (contraception, cancer screening, etc.), we are no longer on very firm ground. How much of our "need" is manufactured, and how much is real? For example, the medical handling of pregnancy in our culture undoubtedly contributes to our anxieties about pregnancy, and anxiety can transform a minor discomfort into an urgent *need* for medical attention. The "need" is real enough at the time, but in a sense it is artificial, manufactured to enhance our dependency on the medical system. Or, more commonly, our very ignorance of our bodies sometimes sends us in search of information and reassurance when no real care is necessary—another case of manufactured dependency.

On the other hand, for all our anger at being dismissed as "psychosomatic" cases when we really do feel sick, we cannot rule out the possibility that many women use sickness as an escape from their oppression as workers and wives. They are not being dishonest, or faking. Our culture encourages people to express resistance as "illness," just as it encourages us to view overt rebellion as "sick." The oppression is real; the resistance is real; but the sickness is manufactured.

Just how "sick" are we then as women? How much of our dependence on the medical system is biological necessity, and how much is social artifice? We spoke before of the contradiction between our rejection of medical ideology and our real dependence on medical technology. But how much of that dependency *is* real? Have we been so blinded by the ideology (which labels us sick, one way or another) that we cannot define the dependency?

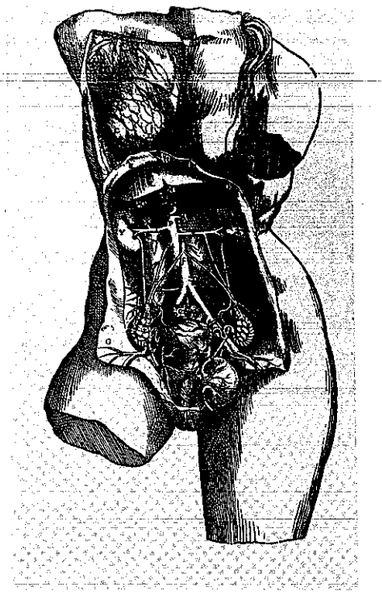
The women's movement has been totally ambivalent about this issue. There are feminists who would deny that we have any special liabilities as women: to them menstrual cramps, nausea in pregnancy, and all the rest are culturally induced,

"curable" with a dose of consciousness-raising and a short course in physiology. However, there are other feminists who seem totally preoccupied with the agonies of menstruation, postpartum depression, or menopause. And there are some who believe that childbirth is so dangerous and so degrading that we should abstain until test-tube babies are available. And there are feminists who believe that childbirth is so healthy and gratifying that it is the peak experience of a woman's life. We seem to alternate between accusing the medical system of treating us as if we were sick and accusing them of not appreciating how sick we are!

The trouble is that whatever we say can be, and is, used against us. Say that menstruation is painful and distressing, and women will be arbitrarily barred from occupations that involve concentration and responsibility. Say that it is unnoticeable and that we are as consistently healthy as males are supposed to be, and all women will be required to lift the same weights and work the same long hours required of men regardless of the degree of discomfort experienced. Say that the last months of pregnancy are difficult, and we will be fired at the first signs of swelling. Say that there is "nothing unhealthy about being pregnant," and we will be held to eight hours a day, five days a week. There are real dangers—for all of us—in either understating or exaggerating our needs as women.

□ There is no "correct line" on our bodies. There is no way to determine our "real" needs, our "real" strengths and liabilities, in a sexist society—any more than there is a way to understand what "female nature" may really be. How can we "know ourselves" when the only images we have of ourselves are images cast by an oppressive society?

There is no way for us to come to terms with our own bodies, in whatever female "subcultures" we may attempt to create, because, when you come right down to it, our *bodies* are not the issue. Biology is not the issue. The issue is power, in all the ways it affects us. We could debate endlessly, for example, about whether premenstrual tension is "real" or psychosomatic, whether the last months of pregnancy are invigorating or debilitating. But the real question is: Who decides the consequences? We could clash over the culture of childbirth, whether or not having test-tube babies would be "healthier" and more liberating than natural childbirth. But



who decides what options will actually be available to us? More important, who controls the social context of childbirth—the availability of abortion at one end and of day care at the other?

This is not to say that we do not need more hard information about our biology and about our health needs. We do. We need to know much more about occupational health hazards specific to women, about actual emotional patterns accompanying menstruation and pregnancy, about the potential hazards of various contraceptive methods, and about many other areas ignored or distorted by medicine. But in our concern to understand more about our own biology, for our own purposes, we must never lose sight of the fact that it is not our *biology* that oppresses us—but a social system based on sex and class domination.

This, to us, is the most profoundly liberating feminist insight—the understanding that our oppression is socially, and not biologically, ordained. To act on this understanding is to ask for more than "control over our own bodies." It is to ask for, and struggle for, control over the social options available to us, and control over all the institutions of society that now define those options.