WOMEN IN MEDICINE.

by SUSAN GOLDSTEIN.

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The position of women in medicine is very similar to the position of women in society in general. Women are exploited and oppressed. The worst paid jobs are seen as women's jobs, for example, nursing, occupational therapists and physiotherapists. Nursing in particular is badly paid and the hours are long. It has been said that nursing is a woman's job because it is similar to housekeeping and mothering - and in the same way very little recognition is given to nurses.

Salary rises in the above jobs are much lower than the salary rises of doctors (proportionally) There is very little consideration for the child bearing function of women - i.e. if a nurse becomes pregnant she has to leave her job (and the same applies to a female doctor who is more than four months pregnant). There are very few crêche facilities. For women doctors to work and have a family, they are forced to specialise.

In this virtually all female medical team (with the male doctor at the head) - the women have no power and are usually forced to abide by the decisions of the doctor, and what is more they hold little power in the overall covering body - the Medical and Dental Council.

Before one can change the situation, one must examine the form exploitation takes, and only then can one move against it.

Research on women in health has been largely inadequate through two basic mistakes. Firstly, the focus has been largely on women themselves, as if they were responsible for the present situation, whereas one should focus on social and economic systems which are controlled largely by men of defined class positions. Secondly,

the health sector is usually seen in a vacuum, instead of looking at society in general to see how the structure of the health sector came into being.

If one looks at the class composition of the United States population, one sees that a relatively small number of people own a disproportionate amount of personal wealth, and whose income is derived from ownership; the Corporate Class of which 0,1% are women.

Then one gets the upper middle class of which 11,3% are women.

The lower middle class can be divided into:

(a) clerical and sales workers - 82,6% of which are women, and

(b) self employed, shop keepers, craftsmen and artisans - 28,6% are women.

The working class can be divided into three sections:

(a) manual labourers - 20% women.

(b) service sector - 83,3% women.

(c) farm labourers - 3,3% women.

Moreover 50% of the lower middle class women are married to working class men.

The position in South Africa, although clouded by race is essentially very similar.

There are numerous reasons for this sex discrimination in the labour force. Two of the important reasons are:

(i) The system of the family, whereby the woman (housewife) does a large amount of necessary labour with no recognition of this labour spent. The Employer pays the husband as one person,

while he is actually benifiting from the labour of two people. This is upheld by socialising women into the emotional rewards system -- that is that the woman is emotionally fulfilled by working and caring for her family. It is also assumed that because of the emotional rewards of the family, a woman can "enjoy" a lower salary than men.

(ii) Women are kept as a reserve labour force for states of crisis such as war.

The class composition of the health sector is similar to that of the labour force in general. There are upper class white male physicians - the unquestioned leaders of the health team, and the lower middle class female nurses who are appendages to and dependant on the physicians. The auxillary and ancillary personel are females of working or lower middle class origin.

More important than the class composition of the health sector is the control and leadership of the sector. We find here (both in S.A. and the U.S.A.) that although about 80% of workers are women (nurses and auxillaries) total control is exerted by the 20% who are physicians.

In Russia the situation is slightly different - 80% of physicians are women, yet the control of the health is still in the hands of males. Less than 10% of the National Health Board are women, and only once in 50 years has the Minister of Health been a woman.

An interesting point to note is that even though there has been an increase in women admitted to medical schools to train as physicians, the class composition of physicians has not changed at all.

At this point an important question to ask is - who is the health sector supposed to serve?

The answer must be - the entire population, 80% of whom are lower middle and working class people, and 50% of whom are women. Yet the control of the health sector is in the hands of a few upper middle class males.

For health services to be effective the interest of all the people must be represented and thus the people to whom the service is directed must have control of that service.

From the above one can see that a strategy for change would be to change the sex and class composition of the government and to have the government representative of and accountable to the majority of the population.

"The Women's Liberation Movement will be ended when and only when --- the process of the social transformation of society as a whole is completed".

(Soong Ching-ling).

Hospital nurses and a pay gap

Pretoria Bureau

There is a gap of more than R112 a month between starting salaries paid to white and black nurses in Transvaal provincial hospitals.

The Administrator, Mr Sybrand van Niekerk told Mrs Irene Menell (PFP Houghton), in the Provincial Council yesterday that whites receive R310 a month, blacks R197,50 and

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